| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CC | ONSTRUCTION | (X3) DATE SURVEY | | |
|--|-----------------------|--------------------------------|------------|-------------|---|-------------------------|---|
| AND PLAN | OF CORRECTION | 155530 | A. BUI | LDING | 00 | COMPLETED 08/22/2014 | |
| | | 100000 | B. WIN | | | 00/22/2014 | |
| NAME OF F | PROVIDER OR SUPPLIE | R | | 353 TY | ADDRESS, CITY, STATE, ZIP CODE | | |
| SOUTH | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | • | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | 1 |
| TAG F000000 | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | - | TAG | DEFICIENCY) | DATE | |
| F000000 | | | | | | | |
| | This visit was f | or a Recertification and | F00 | 0000 | | | |
| | State Licensure | | | | | | |
| | | | | | | | |
| | Survey dates: A | ugust 18, 19, 20, 21, and | | | | | |
| | 22, 2014. | | | | | | |
| | , | | | | | | |
| | Facility number | : 000369 | | | | | |
| | Provider numbe | | | | | | |
| | Aim number: 100275190 | | | | | | |
| | | | | | | | |
| | Survey team: | | | | | | |
| | Heather Tuttle, I | RN,-TC | | | | | |
| | Lara Richards, I | | | | | | |
| | Cynthia Stramel | | | | | | |
| | Yolanda Love, I | | | | | | |
| | ŕ | | | | | | |
| | Census bed type | : : | | | | | |
| | SNF/NF: 70 | | | | | | |
| | Total: 70 | | | | | | |
| | | | | | | | |
| | Census payor ty | rpe: | | | | | |
| | Medicare: 10 | | | | | | |
| | Medicaid: 58 | | | | | | |
| | Other: 2 | | | | | | |
| | Total: 70 | | | | | | |
| | | | | | | | |
| | | ies reflect State findings | | | | | |
| | | nce with 410 IAC | | | | | |
| | 16.2-3.1. | | | | | | |
| | | 1 . 1 | | | | | |
| | • | completed on August 28, | | | | | |
| | 2014, by Janely | n Kulik, KN. | | | | | |
| | | | | | 1 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530 | | (X2) MULTIPLE CO A. BUILDING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 09/32/2014 | |
|---|--|--|----------------|---|------------|
| | | 155530 | B. WING | | 08/22/2014 |
| | PROVIDER OR SUPPLIE SHORE HEALTH & | REHABILITATION CENTER | 353 TY | ADDRESS, CITY, STATE, ZIP CODE LER ST IN 46402 | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | * | ICY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| F000157 SS=D | 483.10(b)(11) NOTIFY OF CHA (INJURY/DECLIN A facility must imresident; consult of physician; and if he legal representation member when the the resident which the potential for resident's physical status (i.e., a deteor psychosocial status (i.e., | NGES E/ROOM, ETC) mediately inform the with the resident's known, notify the resident's rown, notify the resident's re is an accident involving in results in injury and has equiring physician mificant change in the all, mental, or psychosocial reforation in health, mental, tatus in either life tions or clinical meed to alter treatment an eatment due to adverse to commence a new form a decision to transfer or ident from the facility as 12(a). Also promptly notify the rown, the resident's legal interested family member mange in room or ment as specified in a change in resident rights State law or regulations as raph (b)(1) of this section. | PREFIX TAG | The facility will ensure that residents, resident's legal representative or interested fa | 09/21/2014 |
| | Based on record the facility failed | review and interview, d to ensure the Physician | F000157 | residents, resident's legal | |
| | was notified of a | i significant weight loss | | member and physician of | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

C5M611

Facility ID: 000369

If continuation sheet

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| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MU | JLTIPLE CO | ONSTRUCTION | (X3) DATE | SURVEY |
|-----------|----------------------|------------------------------|---------|------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | | nn.a | 00 | COMPL | ETED |
| | | 155530 | A. BUII | | | 08/22/ | /2014 |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | | | |
| COLITIL | SHODE HEALTH 6 | REHABILITATION CENTER | | | LER ST | | |
| 3001113 | SHUKE HEALTH & | REHABILITATION CENTER | | GART, | IN 46402 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | EFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | and a resident's | responsible party was | | | changes of room, roommate | | |
| | notified of a cha | nge in status for 3 of 3 | | | assignment or weight status Residents identified have had | | |
| | residents review | ed for notification of | | | review to determine if any oth | | |
| | change (Reside | ents #37, #79, and #87) | | | notifications requirements have | | |
| | onungo. (11051410 | , | | | not been met No new issues | C | |
| | Findings include: | | | | noted A further review of cha | rts | |
| | | | | | from every unit have been | | |
| | | | | | reviewed to ensure that no oth | ner | |
| | | or Resident #79 was | | | residents were affected by | | |
| | reviewed on 8/2 | 1/14 at 10:59 a.m. | | | deficient practice Nurses will | | |
| | Review of the re | sident's weekly weight | | | notify family members of char | | |
| | sheet indicated t | he resident weighed 138 | | | in status and/or condition Nui will be in-serviced on notificati | | |
| | | 4. On 4/9/14, the | | | protocol Social Services Dire | | |
| | | d 128 pounds, a greater | | | or designee will be responsible | | |
| | _ | loss within the week. | | | for monitoring changes in room | | |
| | 1 | | | | or roommates. An intra- facil | | |
| | | cumentation in the | | | transfer form has been develo | ped | |
| | _ | ary Progress Notes to | | | and will be monitored by Socia | al | |
| | indicate the resid | dent's Physician had been | | | Services or designee at least | | |
| | notified of the si | gnificant weight loss. | | | daily to ensure that notification | ו | |
| | | | | | occurs per policy. Dietary | | |
| | Interview with the | he House Supervisor on | | | Manager will be responsible for monitoring changes in weights | | |
| | | a.m., indicated the | | | Changes in weights will be | , | |
| | | tian should have been | | | reviewed during weekly NAR | | |
| | <u> </u> | | | | (Nutrition as Risk) and auditin | g of | |
| | notified of the w | | | | notification will be conducted | at | |
| | | or Resident #87 was | | | that time to ensure continued | | |
| | | 0/14 at 10:10 a.m. The | | | compliance. Both Social | ••• | |
| | resident was adn | nitted to the facility on | | | Services and Dietary Manage | r will | |
| | 3/25/14. The res | sident was admitted to | | | follow up to ensure that notification occurs per Room | | |
| | the hospital on 5 | 5/21/14 and readmitted to | | | Transfer Documentation and | ner | |
| | _ | 18/14. The resident's | | | weekly weights. DON or design | | |
| | | led, but were not limited | | | will monitoring changes to ver | | |
| | 1 | · · | | | notification as well Results of | | |
| | | lood stream, pneumonia, | | | audits and monitoring will be | | |
| | hypercholesterol | - | | | reported to QA for 6 months of | | |
| | | e, high blood pressure, | | | monthly basis until problem is | | |
| | dysphagia, apha | sia, insomnia, and | | | considered resolved Problen | 1 | |

| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) I | | | X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | |
|-----------|---|------------------------------|--------|--|---|------------|--|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DIII | LDING | 00 | COMPLETED | | |
| | | 155530 | B. WIN | | | 08/22/2014 | | |
| | | | B. WII | | ADDRESS, CITY, STATE, ZIP CODE | | | |
| NAME OF P | PROVIDER OR SUPPLIER | 8 | | 353 TYI | | | | |
| SOUTH S | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | | |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' | COMPLETION | | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE | | |
| | anemia. | | | | will be considered resolved wh | ien | | |
| | | | | | audits show no new issues for | а | | |
| | Interview with the | he resident's Power of | | | period of 3 months. | | | |
| | Attorney (POA) | on 8/18/14 at 3:21 p.m., | | | | | | |
| | • ` ' | g staff does not always | | | | | | |
| | | her sister's treatments or | | | | | | |
| | | | | | | | | |
| | medications wer | e changed. | | | | | | |
| | Review of the A | dmission Minimum Data | | | | | | |
| | | | | | | | | |
| | Set (MDS) Assessment dated 6/24/14 indicated the resident had a Brief | | | | | | | |
| | Interview for Mental Status (BIMS) score | | | | | | | |
| | | | | | | | | |
| | | she was not alert and | | | | | | |
| | | sident had no behaviors | | | | | | |
| | _ | dependent on staff for her | | | | | | |
| | | ily Living. The resident | | | | | | |
| | had a Percutaneo | ous Endoscopic | | | | | | |
| | Gastrostomy (PI | EG) tube as well as an | | | | | | |
| | indwelling foley | catheter. | | | | | | |
| | Review of Physi | cian Orders dated | | | | | | |
| | | d the resident was started | | | | | | |
| | | Augmentin ES 600 | | | | | | |
| | | • | | | | | | |
| | | give 5 cubic centimeters | | | | | | |
| | | (tsp) twice a day times 7 | | | | | | |
| | days for a respira | atory intection. | | | | | | |
| | Review of the N | ursing Progress Notes | | | | | | |
| | | dicated there was no | | | | | | |
| | | on indicating there had | | | | | | |
| | been a change in | C | | | | | | |
| | medications. | i inc residents | | | | | | |
| | incuications. | | | | | | | |
| | Review of Physi | cian Orders dated 7/1/14, | | | | | | |

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Event ID:

C5M611 Facility ID: 000369

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| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530 | | LDING | NSTRUCTION 00 | (X3) DATE COMPI 08/22 | LETED |
|--------------------------|--|--|---|---------------------|---|------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | REHABILITATION CENTER | • | 353 TYL | DDRESS, CITY, STATE, ZIP CODE LER ST N 46402 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| | indicated cleanse wound wash and ointment and app dressing. | * * * | | | | | |
| | 7/1/14 indicated | ng Progress Notes dated there was no family rding the new open area coccyx area. | | | | | |
| | 1 | cian Orders dated 7/7/14, 5 mg twice a day for low | | | | | |
| | dated 7/7/14 indifamily notification hemoglobin or the | cated there was no on regarding the low ne addition of an iron e resident's medication | | | | | |
| | Notification for C Condition or Sta the Director of N facility and/or fa notify appropriat Administrator, D Guardian, HCPC resident's medica and/or status. Ex emergencies, not | OA, ect) of changes in the al/mental condition | | | | | |
| <u> </u> | occurring in the | resident's medical/mental | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

C5M611

Facility ID: 000369

If continuation sheet

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| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530 | A. BUII | LDING | NSTRUCTION 00 | COMP | E SURVEY LETED 2/2014 |
|--------------------------|---|---|---------|---------------------|--|----------|-----------------------------|
| | PROVIDER OR SUPPLIER | | B. WIN | STREET A | .DDRESS, CITY, STATE, ZIP C .ER ST IN 46402 | | |
| (X4) ID PREFIX TAG | SUMMARY S' (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| | Interview with the 8/20/14 at 2:30 pstaff were to information their responsible was a change in or a need to alter 3. The record for reviewed on 8/2 resident was adm 6/18/14. The resident was admitted, but we secondary to propose admitted with a factor to the secondary to propose admitted with a factor to the secondary to propose admitted with a factor to the secondary to propose admitted with a factor to the secondary to propose admitted with a factor to the secondary to propose admitted with a factor to the secondary to propose admitted with a factor to the secondary to propose admitted with a factor to the secondary to propose admitted with a factor to the secondary to propose admitted with a factor to the secondary to propose admitted with a factor to the secondary to propose admitted with a factor to the secondary to propose admitted with a factor to the secondary to propose a factor to the secondary to the secondary to propose a factor to the secondary to the | ne Director of Nursing on o.m., indicated nursing orm the resident and/or party whenever there the resident's condition treatment. Resident #37 was 1/14 at 2:46 p.m. The nitted to the facility on sident diagnoses are not limited to, sepsis remonia. He was feeding tube and urinary Minimum Data Set d 6/25/14 indicated the rendant for transferring to. The resident was a hospital on 7/13/14. Reights were as follows: ounds ounds ounds ands | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

C5M611

Facility ID: 000369

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION OF CORRECTION 155530 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | COMF 08/22 | E SURVEY PLETED 2/2014 |
|--------------------------|---|--|--|---------------|------------------------------|
| SOUTH | PROVIDER OR SUPPLIER SHORE HEALTH & REHABILITATION CENTER | 353 TYI | ADDRESS, CITY, STATE, ZIP CO LER ST IN 46402 | DDE | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| | On the weight record, a notation was written the resident received Lasix (a diuretic) 20 milligrams (mg) daily for edema and "could be water wt (weight)". There were no additional Registered Dietitian (RD) notes or recommendations for the remainder of the residents stay. There were no additional Physician orders related to nutrition. There was no documentation the Physician had been notified of the significant weight loss. Interview with the RD and the Dietary Manager (DM) on 8/22/14 at 10:40 a.m. the RD indicated she had not received notification of the significant weight loss. The facility would fax a referral form to her if there were changes so she could address issues between visits. She indicated when she returned to the facility in July she had been notified the resident was not in the facility any longer. Interview with the House Supervisor on 8/22/14 10:00 a.m. indicated the Physician and Dietician should have been notified of the significant weight loss. Review of the current 12/06 facility policy titled "Resident Weight Monitoring" on 8/22/14 at 9:05 a.m., provided by the House Supervisor, indicated "If there is an actual significant | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

C5M611

Facility ID: 000369

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULT | TIPLE CO | NSTRUCTION | (X3) DATE S | SURVEY |
|--|----------------------|---|------------|----------|---|-------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDII | NG | 00 | COMPL | ETED |
| | | 155530 | B. WING | | | 08/22/ | 2014 |
| | | | | TREET A | DDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | ROVIDER OR SUPPLIE | R | 3 | 353 TYL | ER ST | | |
| SOUTH | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | I | D | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · · | NCY MUST BE PRECEDED BY FULL | | EFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | T | AG | DEFICIENCY) | | DATE |
| | weight change, | - | | | | | |
| | family/guardian | , physician and dietitian | | | | | |
| | are notified. Th | e date of the notification | | | | | |
| | is documented i | n the Nursing Progress | | | | | |
| | notes." | | | | | | |
| | | | | | | | |
| | 3.1-5(a)(2) | | | | | | |
| | 2.1 v(u)(=) | | | | | | |
| | | | | | | | |
| F000225 | 483.13(c)(1)(ii)-(ii | | | | | | |
| SS=E | INVESTIGATE/R | | | | | | |
| | ALLEGATIONS/II | | | | | | |
| | • | not employ individuals who | | | | | |
| | have been found | streating residents by a | | | | | |
| | | ave had a finding entered | | | | | |
| | | se aide registry concerning | | | | | |
| | | nistreatment of residents or | | | | | |
| | misappropriation | of their property; and report | | | | | |
| | | has of actions by a court of | | | | | |
| | • | nployee, which would | | | | | |
| | | for service as a nurse aide | | | | | |
| | registry or licensi | aff to the State nurse aide | | | | | |
| | legistry or neerisii | ng authornics. | | | | | |
| | The facility must of | ensure that all alleged | | | | | |
| | | ig mistreatment, neglect, or | | | | | |
| | | njuries of unknown source | | | | | |
| | | tion of resident property | | | | | |
| | are reported imm | | | | | | |
| | | ne facility and to other | | | | | |
| | | ance with State law ed procedures (including to | | | | | |
| | | and certification agency). | | | | | |
| | | and commoducin agency). | | | | | |
| | The facility must I | have evidence that all | | | | | |
| | alleged violations | are thoroughly | | | | | |
| | • | must prevent further | | | | | |
| | - | hile the investigation is in | | | | | |
| | progress. | | | | | | |

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Event ID:

C5M611 Facility ID: 000369

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CC | ONSTRUCTION | (X3) DATE | SURVEY | |
|--|----------------------|---|------------|-------------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A RIII | LDING | 00 | COMPL | ETED |
| | | 155530 | B. WIN | | | 08/22/ | 2014 |
| | | | D. WII | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | LER ST | | |
| SOUTH | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | nvestigations must be | | | | | |
| | reported to the ad | | | | | | |
| | | sentative and to other ance with State law | | | | | |
| | (including to the S | | | | | | |
| | | cy) within 5 working days of | | | | | |
| | | f the alleged violation is | | | | | |
| | | te corrective action must | | | | | |
| | be taken. | | | | TI 6 319 31 4 4 5 5 | | |
| | | review and interview, | F00 | 0225 | The facility will ensure that all employees receive required | | 09/21/2014 |
| | 1 | d to obtain the required | | | pre-screening prior to | | |
| | pre-screening pr | ocedures for all new | | | employment Employees | | |
| | employees hired | by the facility related to | | | identified during survey have h | nad | |
| | criminal history | background checks for 4 | | | criminal backgrounds process | | |
| | of 10 employee | files reviewed. (CNA #4, | | | No issues noted Other files ha | ave | |
| | Dietary Aide #1. | , Activity Aide #1, and | | | been reviewed to ensure that | No. | |
| | Housekeeper #1 | | | | practice did not affect others I issues noted Business Office | NO | |
| | | , | | | Manager or designee will ensu | ıre | |
| | Findings include | 7. | | | that all files are complete prior | | |
| | 1 manigs merade | | | | employees starting work Only | | |
| | The Employee f | iles were reviewed on | | | employees with complete files be allowed to proceed with | will | |
| | | a.m. The following | | | orientation New employee file | ıs. | |
| | | hired and there was no | | | will be reviewed by QA Team | | |
| | | | | | designee prior to orientation | | |
| | | inal history background | | | Audits will be reported to QA f | or 6 | |
| | | completed prior to or at | | | months or until problem is | | |
| | the time of empl | loyment: | | | considered resolved. | | |
| | | | | | | | |
| | A. CNA #1 was | s hired on 8/5/14 and | | | | | |
| | there was no crit | minal history background | | | | | |
| | check completed | d. | | | | | |
| | | | | | | | |
| | B. Dietary Aide | e #1 was hired on 8/1/14 | | | | | |
| | 1 | o criminal history | | | | | |
| | background che | - | | | | | |
| | background check | ck completed. | | | | | |
| | C. Activity Aid | e #1 was hired on | | | | | |

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Event ID:

C5M611 Facility ID: 000369

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | |
|--|----------------------------|---|---------------|---|-----------------|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED |
| | | 155530 | B. WING | | 08/22/2014 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP CODE | |
| 00117110 | NIODE LIEAL TIL A | DELIABILITATION OF NEED | | LER ST | |
| SOUTHS | SHORE HEALTH & | REHABILITATION CENTER | GARY, | IN 46402 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) |
| PREFIX TAG | ` | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | COMPLETION DATE |
| TAG | | e was no criminal history | TAG | | DATE |
| | background chec | | | | |
| | background chec | ck completed. | | | |
| | D Housekeener | #1 was hired on 6/5/14 | | | |
| | and there was no | | | | |
| | background chec | - | | | |
| | background chec | ek completed. | | | |
| | Interview with th | ne Business Office | | | |
| | Manager on 8/22 | | | | |
| | _ | ninal history checks for | | | |
| | | yees had not been | | | |
| completed. | | | | | |
| | completed. | | | | |
| | 3.1-28(a) | | | | |
| | | | | | |
| F000000 | 400 40/-) | | | | |
| F000226 SS=E | 483.13(c) DEVELOP/IMPLM | IENT ABUSE/NEGLECT, | | | |
| 00-L | ETC POLICIES | ient Abooemeoelot, | | | |
| | | evelop and implement | | | |
| | • | d procedures that prohibit | | | |
| | mistreatment, neg | appropriation of resident | | | |
| | property. | appropriation of resident | | | |
| | Based on record | review and interview, | F000226 | The facility will ensure that all | 09/21/2014 |
| | the facility failed | to follow the facility's | | employees receive required | |
| | policy for obtain | ing the required | | pre-screening prior to employment Employees | |
| | pre-screening pro | ocedures for all new | | identified during survey have h | ad |
| | employees hired | by the facility related to | | criminal backgrounds processe | |
| | criminal history | background checks for 4 | | No issues noted Other files ha | ıve |
| | of 10 employee f | files reviewed. (CNA #4, | | been reviewed to ensure that practice did not affect others. | _{No} |
| | Dietary Aide #1, | Activity Aide #1, and | | issues noted Business Office | |
| | Housekeeper #1) | | | Manager or designee will ensu | |
| | | | | that all files are complete prior employees starting work Only | |
| | Findings include | : | | employees starting work. Only employees with complete files | |
| | | | | be allowed to proceed with | |

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Event ID:

C5M611 Facility ID: 000369

If continuation sheet Page 10 of 77

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | | |
|--|--|------------------------------|------------|------------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 155530 | B. WIN | IG | | 08/22/ | 2014 |
| NAME OF F | PROVIDER OR SUPPLIER | 3 | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 353 TYI | | | |
| SOUTH | SHORE HEALTH & | REHABILITATION CENTER | | GARY, | IN 46402 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCY) | | DATE |
| | The Employee files were reviewed on | | | | orientation New employee file will be reviewed by QA Team | | |
| | 8/22/14 at 11:30 a.m. The following | | | | designee prior to orientation | J1 | |
| | | hired and there was no | | | Audits will be reported to QA for | or 6 | |
| | | nal history background | | | months or until problem is | | |
| | | completed prior to or at | | | considered resolved. | | |
| | the time of empl | oyment: | | | | | |
| | | 1: 1 0/5/14 | | | | | |
| | | s hired on 8/5/14 and | | | | | |
| | | minal history background | | | | | |
| | check completed. | | | | | | |
| | B. Dietary Aide #1 was hired on 8/1/14 | | | | | | |
| | and there was no criminal history | | | | | | |
| | background chec | | | | | | |
| | background check | ck completed. | | | | | |
| | C. Activity Aid | e #1 was hired on | | | | | |
| | I | e was no criminal history | | | | | |
| | background chec | • | | | | | |
| | | • | | | | | |
| | D. Housekeeper | #1 was hired on 6/5/14 | | | | | |
| | and there was no | criminal history | | | | | |
| | background chec | ck completed. | | | | | |
| | | | | | | | |
| | Review of the cu | arrent 3/26/09 | | | | | |
| | Employment Re | cords Required policy | | | | | |
| | provided by the | Business Office Manager | | | | | |
| | indicated "The h | ealth care employer shall | | | | | |
| | retain on file for | a period of 5 years | | | | | |
| | records of crimin | nal record requests for all | | | | | |
| | | health care employer | | | | | |
| | | by of the disclosure and | | | | | |
| | | rms, a copy of the live | | | | | |
| | | n, all notifications | | | | | |
| | _ | ne fingerprint based | | | | | |
| | | <i>3</i> - F | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY |
|------------------------------------|--|------------------------------|------------------|---|------------------|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED |
| | | 155530 | B. WING | | 08/22/2014 |
| | | <u> </u> | STREET A | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF P | ROVIDER OR SUPPLIER | | 353 TY | LER ST | |
| SOUTH S | | REHABILITATION CENTER | | IN 46402 | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| | criminal history | records check and | | | |
| | waiver, if approp | oriate, for the duration of | | | |
| | the individuals e | mployment. The health | | | |
| | care worker employer shall retain a screen print of the background check | | | | |
| | | | | | |
| | • | which documents that the | | | |
| | | nduct an Internet search | | | |
| | | from the links provided | | | |
| | | - | | | |
| | through the Health Care Worker Registry." | | | | |
| | | | | | |
| Later in the day Both Com | | | | | |
| Interview with the Business Office | | | | | |
| | Manager on 8/22 | • | | | |
| | indicated the crir | minal history checks for | | | |
| | the above employ | yees had not been | | | |
| | completed. | | | | |
| | | | | | |
| | 3.1-28(a) | | | | |
| | | | | | |
| F000241 | 483.15(a) | | | | |
| SS=D | DIGNITY AND RE | SPECT OF | | | |
| 00-B | INDIVIDUALITY | | | | |
| | | romote care for residents | | | |
| | in a manner and ir | n an environment that | | | |
| | | nces each resident's | | | |
| | | t in full recognition of his | | | |
| | or her individuality | | E000241 | The facility will ensure that each | ch 00/21/2014 |
| | | ation, record review, and | F000241 | resident's dignity is maintained | 0 / 1 / 1 0 1 . |
| | | cility failed to ensure | | The two residents identified | |
| | | ignity was maintained | | during the survey have been | |
| | | erring to dependent | | monitored with no negative | |
| | | quired assistance with | | outcome. Other residents hav | |
| | eating as "feeder | s" for 2 of 2 residents | | been interviewed to ensure that | JK. |
| | reviewed for dig | nity. (Residents #42 and | | their dignity has not been compromised. Interviews have | e |
| | #62) | | | revealed no new issues | |
| | | | L | | |

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Event ID:

C5M611 Facility ID: 000369

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| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MU | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|-----------|--|--------------------------------|---------|----------------------------|---|--------|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED | |
| | | 155530 | B. WIN | | | 08/22/ | /2014 | |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | | | |
| NAME OF I | PROVIDER OR SUPPLIE | ER | | 353 TY | LER ST | | | |
| SOUTH | SHORE HEALTH 8 | & REHABILITATION CENTER | | | IN 46402 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | • | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE | COMPLETION | |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION) | _ | TAG | DEFICIENCY) | | DATE | |
| | | | | | identified. Staff will be in-serving on resident dignity with an | ricea | | |
| | Findings include: | | | | emphasis on not referring to | | | |
| | | | | | residents as feeders. Social | | | |
| | 1. On 8/19/14 | at 12:25 p.m. LPN #2 was | | | Services Director will interview | N | | |
| | observed standi | ing outside of the 400 unit | | | residents and/or staff at least | | | |
| | dining room. A | at that time, she indicated | | | weekly to ensure that deficier | | | |
| | "the residents w | who ate in this dining room | | | practice doesn't reoccur. Res of interviews will be reported | | | |
| | | nselves, however there | | | the QA Team on a monthly ba | | | |
| | | n the room also." | | | until problem is considered | | | |
| | | | | | resolved. Problem will be | | | |
| | 2 On 8/21/14: | at 12:43 p.m., Resident | | | considered resolve when ther | | | |
| | #42 was observed in a wheelchair in the 400 unit dining room. At that time, he | | | | are no new issues identified for months. | or 3 | | |
| | | | | | months. | | | |
| | _ | his meal tray to be | | | | | | |
| | _ | ued observation indicated | | | | | | |
| | • | | | | | | | |
| | ^ | assing meal trays to the | | | | | | |
| | | e unit. At that time, the | | | | | | |
| | | heard speaking to the floor | | | | | | |
| | | (Resident name) is a | | | | | | |
| | feeder, he gets | his tray last." | | | | | | |
| | | | | | | | | |
| | | ation on 8/21/14 at 12:43 | | | | | | |
| | p.m., Resident | #62 was observed sitting | | | | | | |
| | in the 400 unit | dining room. At that time, | | | | | | |
| | CNA #1 was of | oserved passing trays to | | | | | | |
| | the resident's in | their rooms as well as the | | | | | | |
| | unit dining room | m. Continued observation | | | | | | |
| | | #1 was almost through | | | | | | |
| | | s she pulled the last one | | | | | | |
| | | and indicated to the floor | | | | | | |
| | - | standing by her, "This is | | | | | | |
| | |), she is a feeder." | | | | | | |
| | | ,, | | | | | | |
| | Interview with | CNA #1 on 8/21/14 at 2 | | | | | | |

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Facility ID: 000369

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE | | | SURVEY | | |
|--|------------------------------|--|-----------|----------|--|----------|------------|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDI | ING | 00 | COMPL | ETED |
| | | 155530 | B. WING | 1110 | | 08/22/ | 2014 |
| | | | | STREET A | DDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| NAME OF P. | ROVIDER OR SUPPLIEI | R | | 353 TYL | | | |
| | SHORE HEALTH & | REHABILITATION CENTER | | GARY, I | IN 46402 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | • | NCY MUST BE PRECEDED BY FULL | | REFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | • | she should not have called | | | | | |
| | | ents "feeders". She | | | | | |
| | | d she was well aware she | | | | | |
| | should not have | done that. | | | | | |
| | 3.1-3(t) | | | | | | |
| | 3.1 - 3(t) | | | | | | |
| F000246 | 483.15(e)(1) | | | | | | |
| SS=D | REASONABLE A NEEDS/PREFER | CCOMMODATION OF | | | | | |
| | | e right to reside and receive | | | | | |
| | | cility with reasonable | | | | | |
| | accommodations | of individual needs and | | | | | |
| | | ept when the health or | | | | | |
| | - | ridual or other residents | | | | | |
| | would be endange | vation and interview, the | F0002 |)16 | Residents will have call lights | | 09/21/2014 |
| | | ensure 1 of 40 residents | 1.0002 | 140 | within reach of their beds. Thi | s | 09/21/2014 |
| | • | Stage 1 of the survey | | | issue was corrected while surv | - | |
| | • | • | | | team was in the facility. All ca | III | |
| | • | ocated next to their bed | | | lights have been checked to ensure proper functioning and | | |
| | on the 300 unit. | (Resident #8) | | | availability. Staff will be | | |
| | Findings include | e: | | | in-serviced on call light | | |
| | C | | | | accessibility. DON or designe will make rounds daily to ensu | re | |
| | | 0:08 a.m., there was no | | | that call lights are within reach | of | |
| | call light availab | ole for Resident #8 who | | | residents. audits will be conducted at least once a shift | + | |
| | resided in bed 1 | . There was a call light | | | Results of rounds will be | ι. | |
| | attached to the r | middle bed and the other | | | reported to the QA Team at lea | ast | |
| | hole for the call | light, had a long plastic | | | monthly for three months or ur | | |
| | cylinder tube in | the hole. | | | problem is considered resolve | | |
| | | | | | ensure continued compliance. Problem will be considered | | |
| | Interview with t | he Maintenance | | | resolved after 30 days of 100% | 6 | |
| | Supervisor at the | e time, indicated the | | | compliance. | | |
| | resident needed | | | | | | |
| | | pervisor indicated the | | | | | |

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Event ID:

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| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MI | JLTIPLE CO | ONSTRUCTION | (X3) DATE S | |
|-----------------|---|--|---------|---------------|---|--------------------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 155530 | A. BUII | LDING | 00 | COMPL 08/22/ | |
| | | 100000 | B. WIN | | | 00/22/ | 2014 |
| NAME OF I | PROVIDER OR SUPPLIER | | | 353 TYI | ADDRESS, CITY, STATE, ZIP CODE | | |
| SOUTH | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY) | ΓE | COMPLETION DATE |
| | resident had rece due to his previo | ently moved to this room us room being under buld have his own call | | | | | |
| F000247 SS=A | before the resident the facility is changed on record the facility failed and/or the resided was notified in a for 1 of 2 resident Admission, Transesidents who may admission, Transesident #87) Findings included Family Interview for Resident #87 been moved to a being her sister's not notified of the The record for Resident #87 reviewed on 8/20 | right to receive notice right to receive notice t's room or roommate in ged. review and interview, I to ensure the resident nt's responsible party dvance of a room change nt's reviewed for sfer, Discharge of the 2 et the criteria for sfer, Discharge. con 8/18/14 at 3:18 p.m. , indicated her sister had different room and she Power of Attorney was the move. | F00 | 0247 | The facility will ensure that residents, resident's legal representative or interested farmember and physician of changes of room, roommate assignment. Residents identif have had a review to determin any other notifications requirements have not been m No new issues noted. A furthe review of charts from every unhave been reviewed to ensure that no other residents were affected by deficient practice. Nurses will notify family membof changes in status and/or condition. Nurses will be in-serviced on notification protocol. Social Services Director designee will be responsible for monitoring changes in room or roommates. An intra-facilit transfer form has been developed and will be monitored by Social Services or designee at least daily to ensure that notification | ried e if net r it e ers | 09/21/2014 |

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PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M | ULTIPLE CO | OO | (X3) DATE : COMPL | |
|-----------|----------------------|---|--------|------------|--|----------------------|------------|
| ANDILAN | OF CORRECTION | 155530 | | LDING | 00 | 08/22/ | |
| | | .0000 | B. WIN | | A DADDEGG CITY OT ATE OF CORE | 33/22/ | |
| NAME OF F | PROVIDER OR SUPPLIER | | | 353 TYI | ADDRESS, CITY, STATE, ZIP CODE | | |
| SOUTH | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | 1 | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | COMPLETION |
| TAG | | m 403. The resident was | + | TAG | occurs per policy. Social Servi | | DATE |
| | | | | | will follow up to ensure that | 003 | |
| | | the hospital on 5/21/14 | | | notification occurs per Room | | |
| | | he facility on 6/18/14. | | | Transfer Documentation. DON | | |
| | room 205. | was readmitted into | | | designee will monitoring chang to verify notification as well | ges | |
| | 100111 203. | | | | Results of audits and monitoring | ng | |
| | Interview with the | ne Admission | | | will be reported to QA for 6 | | |
| | | 8/22/14 at 11:06 a.m., | | | months on a monthly basis un problem is considered resolve | | |
| | | e the resident was out of | | | Problem will be considered | u | |
| | | er than 15 days, the | | | resolved when audits show no | | |
| | | cally discharged her. | | | new issues for a period of 3 | | |
| | | at was the facility's | | | months. | | |
| | | She further indicated, she | | | | | |
| | | couple of days in | | | | | |
| | 1 | esidents were going to | | | | | |
| | | lity. She indicated she | | | | | |
| | had not notified | the resident's Power of | | | | | |
| | Attorney the resi | ident would be returning | | | | | |
| | to a different roc | om. The Admission | | | | | |
| | Coordinator indi | cated sometimes the | | | | | |
| | nurses will call t | he resident's family and | | | | | |
| | let them know w | hat room they are in | | | | | |
| | after they have r | eturned. | | | | | |
| | | | | | | | |
| | | irrent and undated Bed | | | | | |
| | 1 2 1 | ided by the Admissions | | | | | |
| | | cated "In the case of an | | | | | |
| | | whose cost of care is paid | | | | | |
| | _ | Federal program, he/she | | | | | |
| | * | bed for the number of | | | | | |
| | 1 - | is reimbursed the per | | | | | |
| | | at resident's care as if the | | | | | |
| | | ually living in the facility. | | | | | |
| | Should the reser | vation days expire under | | | | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530 | | | (X2) MU A. BUIL B. WINC | DING | NSTRUCTION 00 | (X3) DATE S COMPL 08/22/ | ETED | |
|--|---|---|---|---------------------|--|--------------------------------|----------------------------|--|
| | PROVIDER OR SUPPLIER | REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) |] | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ſΕ | (X5) COMPLETION DATE | |
| | shall have the op at the private rate deemed necessar Interview with th Coordinator on 8 indicated the cur | 2/22/14 at 11:10 a.m., rent Bed Hold policy | | | | | | |
| | State Assistance the facility for th was in the hospit indicated, there we ensure residents members were no | vas no other policy to | | | | | | |
| F000250 SS=D | SOCIAL SERVICE The facility must p social services to a highest practicable psychosocial well- Based on observa interview, the fac medically related provided related | MEDICALLY RELATED Erovide medically-related attain or maintain the ephysical, mental, and being of each resident. atton, record review and cility failed to ensure It social services were to arranging an Oral pappointment for 1 of 3 | F000 | 0250 | The facility will ensure that folloup appointments are arranged ordered. Resident identified is the process of getting a guardian. The responsible par failed and continues to fail to | as in ty | 09/21/2014 | |
| | | ed for Dental Services of e criteria for Dental | | | approve resident's surgery. Or guardian is assigned, surgery proceed. Other appointments | | | |

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Event ID:

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Facility ID: 000369

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SU | URVEY |
|--|----------------------|------------------------------|--------|------------|--|--------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLE' | TED |
| | | 155530 | B. WIN | | | 08/22/2 | 014 |
| | | <u> </u> | _ | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | t . | | 353 TYI | _ER ST | | |
| SOUTH | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ГЕ | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | | | DATE |
| | Services. (Resid | lent #7) | | | have been reviewed to ensure | | |
| | | | | | compliance with other resident No issues noted. Residents w | | |
| | Findings include | : : | | | have guardians, responsible | 110 | |
| | | | | | parties who failed to respond to | 0 | |
| | On 8/20/14 at 9.4 | 44 a.m., Resident #7 was | | | the facility after three attempts | | |
| | | room. The resident had | | | be assigned guardians. Social | | |
| | | and carious teeth. | | | Services/DON or designees w | ill | |
| | manipie missing | , and carroup tooth. | | | monitor per 24-hour report to ensure that families are notifie | . | |
| | The record for D | esident #7 was reviewed | | | per policy. Audits of 24-hour | u | |
| | | 16 a.m. A Dental | | | report will occur daily. Results | s of | |
| | | | | | monitoring will be reported to t | | |
| | | ted 6/13/14, indicated the | | | QA Team for 3 months or until | | |
| | | giene was poor and he | | | problem is considered resolved | | |
| | | igival tissue (gum tissue). | | | Problem is considered resolve when no issues are noted for a | | |
| | I - | Nursing progress notes | | | period of 3 months | 1 | |
| | dated 6/16/14, in | idicated the oral | | | period of a mentile | | |
| | surgeon's office | was contacted regarding | | | | | |
| | an appointment | for a full mouth | | | | | |
| | extraction. An a | ppointment was made | | | | | |
| | for 7/15/14. | | | | | | |
| | | | | | | | |
| | Documentation i | in the Nursing progress | | | | | |
| | | /14 at 11:15 a.m., | | | | | |
| | | ident returned from the | | | | | |
| | | fice without incident. No | | | | | |
| | • | given and a consent | | | | | |
| | | ned by the resident's | | | | | |
| | | Attorney) before the | | | | | |
| | · · | t could be scheduled. | | | | | |
| | | nsent was signed for oral | | | | | |
| | · · | • | | | | | |
| | " | sthesia. Consent signed | | | | | |
| | | f remaining teeth due to | | | | | |
| | chronic dental at | oscess." | | | | | |
| | On 7/25/14 at 2: | 00 p.m. documentation | | | | | |

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Facility ID: 000369

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION IDENTIFICATION NUMBER: | (X2) MULTIPLE CO | NSTRUCTION 00 | (X3) DATE SURVEY COMPLETED |
|---------------|---|---------------------|---|-----------------------------|
| | 155530 | A. BUILDING | | 08/22/2014 |
| | | B. WING STREET A | DDRESS, CITY, STATE, ZIP CODE | |
| NAME OF F | PROVIDER OR SUPPLIER | 353 TYL | | |
| SOUTH | SHORE HEALTH & REHABILITATION CENTER | GARY, | IN 46402 | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | COMPLETION DATE |
| TAG | in the Nursing progress notes indicated | IAG | | DATE |
| | the resident's tooth extraction was | | | |
| | scheduled for 7/29/14 at 12:30 p.m. | | | |
| | | | | |
| | On 7/29/14 at 12:00 p.m., the resident | | | |
| | was transported to the hospital for his | | | |
| | tooth extraction. Documentation in the | | | |
| | Nursing progress notes at 4:00 p.m., | | | |
| | indicated the resident returned from the | | | |
| | hospital without having any tooth | | | |
| | extractions done due to no consent from POA. Social Service made aware. | | | |
| | FOA. Social Service made aware. | | | |
| | There was no further documentation in | | | |
| | the Nursing or Social Service progress | | | |
| | notes related to obtaining consent for the | | | |
| | resident's tooth extraction. | | | |
| | Transition (d. des Grein) Greening | | | |
| | Interview with the Social Service Director on 8/20/14 at 3:15 p.m., | | | |
| | indicated there was no follow up with the | | | |
| | resident's POA to obtain consent for the | | | |
| | teeth extraction after 7/29/14. | | | |
| | | | | |
| | 3.1-34(a) | | | |
| | | | | |
| F000278 | 483.20(g) - (j) | | | |
| SS=D | ASSESSMENT | | | |
| | ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the | | | |
| | resident's status. | | | |
| | A registered nurse must conduct or | | | |
| | coordinate each assessment with the | | | |
| | appropriate participation of health | | | |
| l . | | 1 | | |

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Event ID:

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| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY | | | SURVEY | |
|----------|---|--|---|---------|---|---------------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | |
| | | 155530 | B. WIN | G | | 08/22/ | 2014 |
| | ROVIDER OR SUPPLIER | REHABILITATION CENTER | | 353 TYI | ADDRESS, CITY, STATE, ZIP CODE LER ST IN 46402 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | * | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | - | TAG | DEFICIENCY) | | DATE |
| | professionals. | | | | | | |
| | the assessment is Each individual whithe assessment maccuracy of that pure Under Medicare a who willfully and king material and false assessment is subpenalty of not more | no completes a portion of nust sign and certify the ortion of the assessment. Ind Medicaid, an individual knowingly certifies a statement in a resident oject to a civil money re than \$1,000 for each | | | | | |
| | and knowingly cau certify a material a resident assessme money penalty of each assessment | nent does not constitute a | | | | | |
| | Based on observ | ation, record review and | F00 | 0278 | The facility will provide dental services for residents as need | ed. | 09/21/2014 |
| | each comprehen accurate related antipsychotic us reviewed for Acthe 6 residents w Activities of Dairesidents review residents who m nutrition. (Residents included) | , | | | Resident identified during survinas had her dentures schedule to replaced. Social Director had completed an audit to ensure to other residents have dentures needed. No new issue noted. During care plan meetings, residents who require dentures will be assessed for dentures of the need for dentures. Social Services or designee will conduct audits at least weekly ensure that residents who requires have them. Results of audits will be reported to the Coteam at least monthly for three months or until problem is | rey ed as that as s or to | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|----------------------|--------------------------------|--------|--------|--|-------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | | | 00 | COMPL | ETED |
| | | 155530 | | LDING | | 08/22 | |
| | | 1.23000 | B. WIN | | |] | == · · |
| NAME OF F | PROVIDER OR SUPPLIE | R | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | LER ST | | |
| SOUTH | SHORE HEALTH 8 | REHABILITATION CENTER | | GARY, | IN 46402 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | ATE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | reviewed on 8/2 | 1/14 at 10:15 a.m. The | | | considered resolved. Problei | | |
| | resident's diagno | oses included but were | | | will be considered resolved a | | |
| | | orbid obesity, depression, | | | 2 months of audits with no ne | | |
| | | • • • | | | issues noted. The facility w | ıll | |
| | and chronic anxiety. | | | | provide dental services for | nt | |
| | | | | | residents as needed. Reside | | |
| | Review of the Q | Quarterly Minimum Data | | | identified during survey has her dentures scheduled to | iau | |
| | Set (MDS) Asse | essment dated 5/23/24 | | | replaced. Social Director has | | |
| | ` / | sident was alert and | | | completed an audit to ensure | | |
| | | ad no mood or behavior | | | other residents have denture | | |
| | | | | | needed. No new issue noted | | |
| | 1 * | resident received an | | | During care plan meetings, | - | |
| | antidepressant f | 3 | | | residents who require denture | es | |
| | antipsychotic m | edication was coded with | | | will be assessed for dentures | | |
| | a zero, indicatin | g she did not take any | | | the need for dentures. Socia | l | |
| | during the asses | • | | | Services will conduct audits a | nt | |
| | during the asses | sment period. | | | least weekly to ensure that | | |
| | | | | | residents who requires have | | |
| | | Medication Administration | | | them. Results of audits will b | _ | |
| | Records (MAR) | s for the months of May, | | | reported to the QA team at le | | |
| | June, July and A | August, 2014 indicated the | | | monthly for three months or u | | |
| | resident had red | ceived Abilify (an | | | problem is considered resolve | ed. | |
| | | edication) 7.5 milligrams | | | Problem will be considered | 4:4- | |
| | | Calcation, 7.5 miningrams | | | resolved after 2 months of au | | |
| | (mg) daily. | | | | with no new issues noted. facility will ensure that reside | | |
| | | | | | receive ADL per assessment | | |
| | | he MDS Coordinator on | | | resident needs Residents | | |
| | 8/21/14 at 1:56 | p.m., indicated she should | | | identified during survey have | | |
| | had coded the A | bilify as an antipsychotic | | | received ADL care per reside | nt | |
| | medication. | 1 3 | | | assessment and consent. No | | |
| | | at 11:00 p.m., Resident | | | new issues noted. Other | | |
| | | | | | residents have been assesse | d to | |
| | #41 was observe | | | | ensure care per resident | | |
| | wheelchair in th | e main dining room. She | | | assessment and consent. No | | |
| | did not appear to | o have any teeth, and was | | | new issues noted. Staff will b | e | |
| | not wearing den | tures. She was also not | | | in-serviced on ADL protocol. | | |
| | wearing eye gla | | | | Shower sheets have been | NDI. | |
| | wearing cyc gla | uses. | | | updated to reflect additional A | | |
| | | | | | services to be rendered. DO | IN Oľ | |
| | I On 8/20/14 at 8: | :29 a.m., Resident #41 | | | designee will audit as least | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR | | | (X3) DATE SURVEY | |
|--|-----------------------------------|--|--------|---------|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A RIII | LDING | 00 | COMPLETED |
| | | 155530 | B. WIN | | | 08/22/2014 |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF P | PROVIDER OR SUPPLIEF | ₹ | | 353 TYI | LER ST | |
| | SHORE HEALTH & | REHABILITATION CENTER | | GARY, | IN 46402 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | | DATE |
| | | ated in her wheelchair in | | | weekly to ensure continued compliance. Results of audits | will |
| | the main dining room. She was not | | | | be reported to QA team at least | |
| | wearing denture | s or eye glasses. | | | monthly or until problem is | |
| | | | | | considered resolved. problem | |
| | | 10 a.m., Resident #41 | | | be considered resolved after 3 | |
| | _ | opelling herself down the | | | months of audits with no new issues noted. The facility will | |
| | 300 hallway tow | ard the nursing station. | | | ensure that medication | |
| | She was not wea | aring dentures or eye | | | classification is documented p | er |
| | glasses. | | | | drug classification Resident | |
| | | | | | identified has had MDS update | |
| | The resident's re | ecord was reviewed on | | | to reflect proper classification medication. Other medication. | |
| | 8/20/14 at 8:32 a | a.m. The resident was | | | have been reviewed per MDS | |
| | originally admit | ted to the facility on | | | ensure proper classification. N | |
| | 1 - | admitted on 3/10/14. The | | | new issues noted. Listing of | |
| | | oses included, but were | | | all psychotropics medications | |
| | not limited to, in | | | | have been provided for referen | |
| | | ypertension, cocaine | | | during MDS process. Compar medication to drug reference | eu |
| | | , and convulsions. | | | guild with each MDS per MDS | |
| | abuse, asiiiiia | , and convuisions. | | | Coordinator. Audit will be | |
| | There was no as | re plan related to dental | | | conducted by MDS Coordinate | |
| | | in the resident's record. | | | or designee twice per week to | |
| | Status of Vision i | in the resident's record. | | | ensure accuracy. Continuing monitoring of classification of | |
| | A Minimum Day | to Cat (MDC) Ot1 | | | drugs will be on-going and any | , |
| | | ta Set (MDS) Quarterly | | | issues noted will be reported to | |
| | | ed 6/13/14, indicated | | | the QA Team. | |
| | | ental status sections, the | | | | |
| | | issues, including being | | | | |
| | | ing no teeth), or having | | | | |
| | 1 | entures. Further review | | | | |
| | | indicated the resident | | | | |
| | had adequate vis | sion, including no use of | | | | |
| | corrective lenses | 5. | | | | |
| ı | | | | | | |
| | | he resident's family | | | | |
| | member on 8/19 | /14 at 12:07 p.m., | | | | |

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| | TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155530 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | (X3) DATE SURVEY COMPLETED 08/22/2014 | | | |
|--------------------------|---|---|---|---------------------------------------|--|--|--|
| | PROVIDER OR SUPPLIER SHORE HEALTH & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | indicated the resident had poor vision and was edentulous. The resident was to wear eye glasses and dentures, however, when visiting with the residents in the facility, the resident never has her eye glasses or dentures in place. | | | | | | |
| | Interview with Resident #41 on 8/20/14 at 9:15 a.m., indicated she wore eye glasses and dentures. She further indicated the facility staff did not assist her in putting on her eye glasses on that morning and she no longer had dentures. | | | | | | |
| | Interview with CNA #2 on 8/20/14 at 12:00 p.m., indicated she assists the resident with feeding and she had not observed the resident with her dentures in place for about a month, she also indicated she had not seen the resident wearing her eye glasses. | | | | | | |
| | 3.1-31(d)(3) | | | | | | |
| F000282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and | F000282 | The facility will ensure that die | tary 09/21/2014 | | | |
| | interview, the facility failed to ensure Physician Orders or Care Plans were followed as written related to following | 1000282 | orders are followed per physic orders. Resident identified du survey has had super cereal removed from his order becau | ian ring | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--------------------------------------|--------------------------------|---------|----------|--|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | | P. P. C. | 00 | COMPL | ETED |
| | | 155530 | A. BUII | | | 08/22/ | |
| | | | B. WIN | | |] 30,22, | · · |
| NAME OF P | PROVIDER OR SUPPLIE | R | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | LER ST | | |
| SOUTHS | SHORE HEALTH & | REHABILITATION CENTER | | GARY, | IN 46402 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | dietary orders for | or 1 of 4 residents | | | resident refuses cereal. Other | | |
| | reviewed for nu | trition, and providing | | | tray cards have been review t | 0 | |
| | | cations for 1 of 1 resident | | | ensure compliance. No new | | |
| | reviewed for dialysis and for 1 of 1 | | | | issues noted. Dietary Manag | er or | |
| | | red for death. Also for | | | designee will monitor tray cards/dietary orders to ensure | ۵. | |
| | | | | | compliance. Physician orders | | |
| | | permacath per the plan of | | | may be modified to reflect | • | |
| | care for 1 of 5 re | esidents reviewed for | | | resident choice. Results of | | |
| | unnecessary dru | gs. (Resident #31, #39, & | | | monitoring will be reported to | the | |
| | #86) | | | | QA Team on a monthly basis | | |
| | , | | | | 3 months or until problem is | | |
| | Findings include | | | | considered resolved. Probler | n | |
| | Findings include | 5. | | | will be considered resolved w | | |
| | | | | | 100% compliance is maintain | | |
| | 1. On 8/20/14 a | t 8:19 a.m., Resident | | | for 2 months. The facility wi | II | |
| | #31's breakfast t | tray was observed in his | | | ensure laboratory tests are | 4 | |
| | room. The tray | card indicated he was to | | | completed as ordered. Resid | ent | |
| | 1 | al (a hot cereal amended | | | identified during survey is no longer a resident of the facility | , | |
| | _ | calories). There was no | | | Other charts have been revie | | |
| | _ | * | | | to ensure compliance with fac | | |
| | super cereal on | his tray, only cornflakes. | | | protocol relevant to lab | ·····y | |
| | | | | | administration. No new issue | s | |
| | On 8/21/14 at 8: | 00 a.m. the resident was | | | noted. Nursing staff will be | | |
| | in his room eating | ng breakfast. There was | | | in-serviced on facility protoco | l for | |
| | no super cereal | on his tray, only | | | laboratory administration. DC | | |
| | cornflakes. | 3, 3 | | | or designee will conduct weel | ĸly | |
| | Communes. | | | | audits for lab to ensure | | |
| | The man : 1 | | | | compliance. Results of labs v | | |
| | | ecord was reviewed on | | | be reported to QA for at 3 mo | | |
| | | a.m. The resident was | | | or until problem is considered resolved. Problem will be | I | |
| | readmitted to the | e facility on 5/17/11. | | | considered resolved when no | | |
| | Resident diagno | ses included, but were | | | new issues are identified for a | | |
| | not limited to. re | enal failure, diabetes, | | | least 2 months. The facility | | |
| | | the knee amputation and | | | ensure that resident receive | | |
| | | • | | | medications per physician ord | ders | |
| | | sident received dialysis | | | Resident on dialysis is receive | ing | |
| | three times a we | eek due to renal failure. | | | medication per physician orde | | |
| | | | | | resident #39 is no longer in th | | |
| | The August 201 | 4 Physician Order | | | facility. Charts have been au | dited | |

| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY |
|-----------|--|------------------------------|---------|------------|---|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BIII | LDING | 00 | COMPLETED |
| | | 155530 | B. WIN | | | 08/22/2014 |
| | | | B. WII. | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF P | PROVIDER OR SUPPLIEF | 8 | | | LER ST | |
| SOUTH | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE |
| | Statement (POS) |) indicated the resident's | | | to ensure that other resident a | re |
| | dietary order wa | s no concentrated sweets, | | | receiving medications per | |
| | double protein every meal, no orange | | | | physician orders. No new issuncted. Nursing staff in-service | |
| | iuice, tomatoes. | bananas or oranges and | | | on State regulation | J |
| | " | e daily in the morning. | | | for controlled substances. Au | dits |
| | _ | _ | | | will be conducted on new | |
| | The super cereal was initially ordered on 6/13/12. | | | | admission and readmission | |
| | 0/13/12. | | | | charts for controlled substance | |
| | | | | | to ensure that orders are filled | |
| | Interview with the House Supervisor on | | | | a timely manner per physician order. Weekly audits of MAR's | |
| | 8/21/14 at 8:10 a.m. indicated the kitchen | | | | will be conducted by the DON | |
| | was supposed to ensure the resident had | | | | designed to ensure compliance | |
| | super cereal on h | nis tray each morning. | | | continues. Audits of MAR's wil | |
| | | | | | on-going. Results of audits wil | l be |
| | Continued obser | vation on 8/20/14 at | | | reported to the QA Team on a | |
| | 11:09 a m indic | cated the resident was | | | monthly basis to ensure | |
| | | g the facility for dialysis. | | | continued compliance. The | |
| | · | the door, LPN #1 handed | | | facility will ensure that nurses assess permacaths per plan o | f |
| | _ | | | | care. Nurse #4 received a | · |
| | him a paper bag | and paperwork. | | | teachable moment related to | |
| | | 4.5.6.41 | | | assessment of permacaths. | |
| | The August 201 | | | | In-service conducted with | |
| | Administration I | | | | nurses related to permacath | |
| | indicated the res | ident was to receive | | | assessment. audits have been conducted to ensure that no of | |
| | sodium bicarbon | nate 200 mg three times a | | | residents are affected by defic | |
| | day at 8:00 a.m., | , 12:00 p.m. and 5:00 | | | practice. Binders have been | |
| | p.m. The order | indicated, "send noon | | | created to identify all dialysis | |
| | | on with resident on | | | access sites. Nurses have be | en |
| | dialysis days". | | | | instructed that binders are | |
| | , 2-2 441, 5 | | | | available to be used and to | |
| | Interview with the | he LPN on 8/20/14 at | | | identify proper sites. Audits of binders will be conducted by D | |
| | | ated the resident did not | | | or designee to ensure continue | |
| | | | | | compliance. Results of audits | |
| | | tions with him to | | | be on-going. Results of audits | |
| ı | dialysis, the bag contained his lunch only. | | | | will be reported to QA on a | |
| | 1 | , he would miss the noon | | | monthly basis to ensure | |
| | dose of medicati | ons. After reviewing the | | | continued compliance. | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | IDENTIFICATION NUMBER: | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE COMPL | |
|-----------|---------------------------------------|------------------------------|--------|------------|---|--------------------|------------|
| ANDILAN | or connection | 155530 | | LDING | 00 | 08/22/ | |
| | | 100000 | B. WIN | | PRESIDENCE CONTROL OF CORP. | 00/22/ | 2014 |
| NAME OF P | PROVIDER OR SUPPLIER | | | 353 TYL | ADDRESS, CITY, STATE, ZIP CODE | | |
| SOUTHS | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | · · · · · · · · · · · · · · · · · · · | ndicated the sodium | | | | | |
| | | ald have been sent to | | | | | |
| | dialysis with hin | 1. | | | | | |
| | • === 1.0 | D 11 | | | | | |
| | | or Resident #39 was | | | | | |
| | | 1/14 at 9:37 a.m. The | | | | | |
| | | nitted to the facility on | | | | | |
| | | sident's diagnoses | | | | | |
| | · · | re not limited to, | | | | | |
| | _ | st cerebral vascular | | | | | |
| | | t sided paralysis. He | | | | | |
| | | th a feeding tube for | | | | | |
| | nutrition and me | dications. | | | | | |
| | TI M 1 2014 | DI COL | | | | | |
| | | Physician Order | | | | | |
| | | ited the resident was to | | | | | |
| | | il (a psychoactive | | | | | |
| | · · | nilligrams (mg) every day | | | | | |
| | _ | ing tube. On the | | | | | |
| | | ninistration Record for | | | | | |
| | · · | Modafinil was circled | | | | | |
| | _ | 3/18/14, which indicated | | | | | |
| | | ad not been given. | | | | | |
| | | dication why the | | | | | |
| | medication was | not given. | | | | | |
| | Tukamia 14 4 | II C : | | | | | |
| | | ne House Supervisor on | | | | | |
| | | p.m. indicated the | | | | | |
| | | not given because it was | | | | | |
| | | n the pharmacy by the | | | | | |
| | - | dicated they should have | | | | | |
| | tollowed up on t | he missing medication. | | | | | |
| | Telephone interv | view on 8/21/14 at 1:10 | | | | | |
| | | | | | | | |

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Event ID:

C5M611

Facility ID: 000369

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

| | | DENTIFICATION NUMBER: 155530 | A. BUILDING B. WING | 00 | COMPLETED 08/22/2014 |
|--------------------------|---|---|---------------------|--|----------------------|
| | PROVIDER OR SUPPLIER SHORE HEALTH & F | REHABILITATION CENTER | 353 T | T ADDRESS, CITY, STATE, ZIP CODE YLER ST ', IN 46402 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | (X5) COMPLETION DATE |
| | indicated the press to the pharmacy of pharmacy was not the phrase "valid a was not written or requirement of co prescriptions. It was facility on 3/10/14 requested to inclust pharmacy did not 3/18/14, and then at that time. 3. On 8/18/14 at 286 was observed in wheelchair. A what to his right chest was admit 3/10/14. His diag were not limited to disease, dialysis, of hypertension. Review of the Carlindicated intervent limited to, manage permacath and RN access site for signification/non-function: redness, swelling infection/non-function. | table to fill it because at Intouch Pharmacy" in the prescription, a introlled medication was faxed back to the 4, again on 3/14/14 and de the wording. The receive it back until medication was sent out 2:23 p.m., Resident # in his room seated in a inte dressing was noted wall. sident #86 was 1/14 at 2:10 p.m. The intention to the facility on moses included, but oo, end stage renal | | | |

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Event ID:

C5M611 Facility ID: 000369

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE | SURVEY | |
|--|---------------------------------|--------------------------------|------------|-------------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A RIIII | LDING | 00 | COMPI | LETED |
| | | 155530 | B. WIN | | | 08/22 | /2014 |
| | | <u> </u> | D. (12) | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIE | ER | | 353 TYI | | | |
| SOUTH | SHORE HEALTH (| & REHABILITATION CENTER | | | IN 46402 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE | | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | pus-like drainag | _ | | | | | |
| | (Medication Ac | lministration | | | | | |
| | Record)/TAR (| Treatment Administration | | | | | |
| | Record). | | | | | | |
| | | | | | | | |
| | Review of the TAR dated 8/1/14, | | | | | | |
| | indicated a Phy | sician's Order dated | | | | | |
| | 1 | dressing to permacath (a | | | | | |
| | | atheter) to right chest wall | | | | | |
| | | e treatment had been | | | | | |
| | <u> </u> | ting the task had been | | | | | |
| | | 14 thru 8/21/14 for all | | | | | |
| | shifts. | 14 thu 5/21/14 for an | | | | | |
| | Silits. | | | | | | |
| | Interview with | LPN #4 on 8/21/14 at | | | | | |
| | | eated she was Resident | | | | | |
| | | arse on the night shift. | | | | | |
| | 1 | resident was a dialysis | | | | | |
| | | • | | | | | |
| | _ | hunt (a hemodialysis | | | | | |
| | / | nis left arm which often | | | | | |
| | | en indicated the resident | | | | | |
| | _ | right permacath due to | | | | | |
| | | declotted during his last | | | | | |
| | 1 1 | At that time, she walked | | | | | |
| | away. Further | interview with LPN #4 at | | | | | |
| | 6:37 a.m., indic | eated she reassessed the | | | | | |
| | resident and no | ted a permacath to his | | | | | |
| | right chest wall | , and further indicated she | | | | | |
| | should have be | en assessing the site. | | | | | |
| | Intomian with | the Director of Nursing | | | | | |
| | | the Director of Nursing | | | | | |
| | ` ′ | 14 at 9:45 a.m., indicated | | | | | |
| | _ | f should have been | | | | | |
| | assessing the re | esident's permacath on all | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV | | | SURVEY | | |
|--|--|--|---------|---------|---|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPL | |
| | | 155530 | B. WIN | G | | 08/22/ | 2014 |
| | PROVIDER OR SUPPLIER | REHABILITATION CENTER | | 353 TYI | ADDRESS, CITY, STATE, ZIP CODE LER ST IN 46402 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | ΓE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | 1 | nitialing the treatment in ompletion of the task. | | | | | |
| | 3.1-35(g)(2) | | | | | | |
| F000312 SS=D | RESIDENTS A resident who is a activities of daily linecessary service nutrition, grooming hygiene. Based on observation interview, the face each resident who Activities of Daireceived assistant and the placement dentures for 3 of Activities of Daireceived in the criteria for th | s to maintain good g, and personal and oral ation, record review and cility failed to ensure to was unable to carry out ly Living (ADL's) ace with nail grooming ant of eye glasses and a residents reviewed for ly Living of the 6 who for Activities of Daily at #3, #41, and #86) at 2:23 p.m., Resident #86 his room seated in a fingernails were noted to ad in need of grooming. time indicated the to have his fingernails | F00 | 0312 | The facility will provide dental services for residents as needer Resident identified during survivals had her dentures schedule to replaced. Social Director has completed an audit to ensure the other residents have dentures needed. No new issue noted. During care plan meetings, residents who require dentures will be assessed for dentures. Social Services or designee will condicate audits at least weekly to ensure that residents who requires has them. Results of audits will be reported to the QA team at least monthly for three months or un problem is considered resolved resolved after 2 months of audit with no new issues noted. The facility will ensure that residents receive ADL per assessment of resident needs Residents identified during survey have received ADL care per residents. | ey ed as hat as or uct e ve st htil d. | 09/21/2014 |
| | | 00 p.m., Resident #86 ing wheeled down the | | | assessment and consent. No | ı | |

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| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MUI | LTIPLE CO | NSTRUCTION | (X3) DATE | |
|--------------------------|--|--|----------|--------------------|--|--|----------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILE | DING | 00 | COMPL | |
| | | 155530 | B. WING | | | 08/22/ | 2014 |
| | PROVIDER OR SUPPLIER | REHABILITATION CENTER | | 353 TYL | DDRESS, CITY, STATE, ZIP CODE LER ST N 46402 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | P | ID REFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| IAU | hall toward the refingernails remaineed of grooming. The record for Reviewed on 8/20 resident was admost admost admost and 3/10/14. His dial were not limited disease, dialysis, hypertension. A Minimum Data Assessment date resident was coge exhibited no reject The resident transive assist of extensive assist of extensive assist of the state | nain dining room, his ined long, dirty, and in g. Lesident #86 was 0/14 at 2:10 p.m. The nitted to the facility on agnoses included, but to, end stage renal, diabetes, and La Set (MDS) Quarterly ad 6/19/14 indicated the antively intact and he action of care behaviors. Insferred with an of one and required an of one with personal | | 140 | new issues noted. Other residents have been assesse ensure care per resident assessment and consent. No new issues noted. Staff will be in-serviced on ADL protocol. Shower sheets have been updated to reflect additional Asservices to be rendered. Shower sheets will be monitored by Door designee to ensure continual compliance. Results of audits be reported to QA team at least monthly for 6 months or until problem is considered resolved after 3 months of au with no new issues noted. | DL wer ON led s will list | DATE |

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| | | | (X2) MU | ULTIPLE CO | NSTRUCTION | (X3) DATE | |
|-------------------------------------|--|------------------------------|---------|------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPL | |
| | | 155530 | B. WIN | | | 08/22/ | 2014 |
| NAME OF P | PROVIDER OR SUPPLIER | t | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| COLITIL | CHODE HEALTH & | DELIADII ITATIONI CENTED | | 353 TYL | | | |
| | | REHABILITATION CENTER | | GARY, | IN 46402 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | _ | TAG | DEFICIENCY) | | DATE |
| | 1 ' | ated the staff do not | | | | | |
| document grooming such as nail care | | | | | | | |
| | | ing ADL's on the | | | | | |
| | | r sheets or in the ADL | | | | | |
| | | indicated the only | | | | | |
| | | of nail care would be | | | | | |
| | completed by the activity staff on the | | | | | | |
| | Daily Activity sl | neet. | | | | | |
| | | | | | | | |
| | On 8/20/14 at 2: | 55 p.m., LPN #7 was | | | | | |
| | observed in the r | resident's room providing | | | | | |
| | nail care. At the | time she indicated the | | | | | |
| | resident's finger | nails were in need of | | | | | |
| | grooming. | | | | | | |
| | | | | | | | |
| | 2. On 8/19/14 at | t 9:31 a.m., Resident #3 | | | | | |
| | was observed in | the main dining room | | | | | |
| | seated at the tabl | le. Her fingernails were | | | | | |
| | | , dirty, and in need of | | | | | |
| | grooming. | | | | | | |
| | | | | | | | |
| | On 8/21/14 at 7: | 05 a.m., Resident #3 was | | | | | |
| | | nain dining room, her | | | | | |
| | | ined long, dirty, and in | | | | | |
| | need of groomin | - · | | | | | |
| | 2.000 01 810011111 | ·o· | | | | | |
| | The record for R | esident #3 was reviewed | | | | | |
| | | :15 a.m. The resident | | | | | |
| | | the facility on 1/13/83. | | | | | |
| | | icluded schizophrenia, | | | | | |
| | | | | | | | |
| | mental disorder, | and dementia. | | | | | |
| | A Minimum D | on Cod (MDC) A1 | | | | | |
| | | ta Set (MDS) Annual | | | | | |
| | Assessment date | ed 7/14/14 indicated the | | | | | |

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Event ID:

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| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | |
|-----------|----------------------------------|------------------------------|--------|------------|--|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLETED | |
| | | 155530 | B. WIN | IG | | 08/22/2014 | |
| NAME OF B | PROVIDER OR SUPPLIER | | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | KOVIDEK OK SUPPLIER | | | 353 TYL | LER ST | | |
| | | REHABILITATION CENTER | | GARY, | IN 46402 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY) | | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCI) | DATE | |
| | | bited no rejection of care | | | | | |
| | | resident transferred with | | | | | |
| | _ | required supervision | | | | | |
| | with personal hygiene. | | | | | | |
| | A Care Plan with no created date | | | | | | |
| | indicated the res | ident needs supervision | | | | | |
| | | e daily with personal | | | | | |
| | | oming due to impaired | | | | | |
| | '' | Interventions included, | | | | | |
| | ~ | ited to, check to ensure | | | | | |
| | | been performed to usual | | | | | |
| | | imited assist as needed. | | | | | |
| | standards, give i | innica assist as necaea. | | | | | |
| | Interview with the | ne resident on 8/21/14 at | | | | | |
| | 9:00 a.m., indica | ted her fingernails were | | | | | |
| | | ning and she desired to | | | | | |
| | have her fingern | • | | | | | |
| | | | | | | | |
| | Review of the D | aily Activity sheet dated | | | | | |
| | August 2014 ind | icated no evidence of | | | | | |
| | documentation tl | he resident had her nails | | | | | |
| | groomed by activ | vities. | | | | | |
| | _ | | | | | | |
| | Interview with C | CNA #2 on 8/21/14 at | | | | | |
| | 1:00 p.m., indica | ited she had trimmed the | | | | | |
| | resident's fingerr | nails today and the last | | | | | |
| | | had her fingernails | | | | | |
| | | ring the group activity in | | | | | |
| | _ | room when activity staff | | | | | |
| | 1 | re. She then indicated | | | | | |
| | | yould be completed by | | | | | |
| | | on the Daily Activity | | | | | |
| | sheet. | on the Dully Metivity | | | | | |
| | SHEEL. | | 1 | | | l | |

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Event ID:

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY |
|--|----------------------|------------------------------|--------|------------|--|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLETED |
| | | 155530 | B. WIN | G | | 08/22/2014 |
| NAME OF D | PROVIDER OR SUPPLIER | | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF P | ROVIDER OR SUPPLIER | | | 353 TYI | LER ST | |
| SOUTH S | | REHABILITATION CENTER | | GARY, | IN 46402 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | `` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY) | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCE) | DATE |
| | 3 On 8/10/14 at | t 11:00 p.m., Resident | | | | |
| | #41 was observe | • | | | | |
| | | | | | | |
| | | e main dining room. She | | | | |
| | | have any teeth, and was | | | | |
| | _ | tures. She was also not | | | | |
| | wearing eye glas | ises. | | | | |
| | On 8/20/14 at 8:2 | 29 a.m., Resident #41 | | | | |
| | | ated in her wheelchair in | | | | |
| | | room. She was not | | | | |
| | wearing dentures | | | | | |
| | wearing dentares | of eye glasses. | | | | |
| | On 8/21/14 at 6: | 10 a.m., Resident #41 | | | | |
| | was observed pro | opelling herself down the | | | | |
| | 300 hallway tow | ard the Nurse's station. | | | | |
| | She was not wea | ring dentures or eye | | | | |
| | glasses. | ž , | | | | |
| | | | | | | |
| | The resident's re- | cord was reviewed on | | | | |
| | 8/20/14 at 8:32 a | .m. The resident was | | | | |
| | | ed to the facility on | | | | |
| | | dmitted on 3/10/14. The | | | | |
| | | ses included, but were | | | | |
| | not limited to, in | | | | | |
| | · · | pertension, cocaine | | | | |
| | | , and convulsions. | | | | |
| | abuse, asiiilla, | , and convuisions. | | | | |
| | A Minimum Dat | a Set (MDS) Quarterly | | | | |
| | | d 6/13/14, indicated the | | | | |
| | | d no rejection of care | | | | |
| | | resident transferred with | | | | |
| | | one assist and was totally | | | | |
| | | • | | | | |
| | i dependent with p | personal hygiene. | | | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | IDENTIFICATION NUMBER: | (X2) M | ULTIPLE CO | 00 | (X3) DATE COMPL | |
|-------------|----------------------|------------------------------|--------|------------|---|--------------------|------------|
| 11112 12111 | or conditions | 155530 | | LDING | | 08/22/ | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | R | | 353 TYL | | | |
| SOUTH | SHORE HEALTH & | REHABILITATION CENTER | | GARY, | IN 46402 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | A Care Plan witl | n no created date | | | | | |
| | | ident required full | | | | | |
| | | pathing, grooming, and | | | | | |
| | | cognitive impairment. | | | | | |
| | _ | cluded, but were not | | | | | |
| | | rage hygiene and | | | | | |
| | · · | sist as needed. There | | | | | |
| | | related to dental status | | | | | |
| | or vision in the r | | | | | | |
| | | | | | | | |
| | Interview with the | ne resident's family | | | | | |
| | member on 8/19 | /14 at 12:07 p.m., | | | | | |
| | indicated the res | ident had poor vision and | | | | | |
| | | The resident was to | | | | | |
| | wear eye glasses | and dentures, however, | | | | | |
| | _ | th the resident in the | | | | | |
| | - | lent never had her eye | | | | | |
| | glasses or dentur | res in place. | | | | | |
| | Interview with the | ne Social Service | | | | | |
| | Director on 8/20 | | | | | | |
| | | ident was being provided | | | | | |
| | | however, she was unsure | | | | | |
| | if she wore denti | · | | | | | |
| | | | | | | | |
| | Interview with R | Resident #41 on 8/20/14 | | | | | |
| | at 9:15 a.m., ind | icated she wore eye | | | | | |
| | glasses and dent | ures. She further | | | | | |
| | indicated the fac | ility staff did not assist | | | | | |
| | her in putting on | her eye glasses that | | | | | |
| | morning and she | no longer had dentures. | | | | | |
| | | | | | | | |
| | Interview with C | QMA #1 on 8/20/14 at | | | | | |

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Event ID:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M | ULTIPLE CO. | NSTRUCTION | (X3) DATE COMPL | |
|-----------|---------------------|---|--------|-------------|---|--------------------|------------|
| ANDILAN | or connection | 155530 | A. BUI | LDING | 00 | 08/22/ | |
| | | 155550 | B. WIN | | | 00/22/ | 2014 |
| NAME OF F | ROVIDER OR SUPPLIER | | | 353 TYL | ADDRESS, CITY, STATE, ZIP CODE | | |
| SOUTH | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | `` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | · · | ted the resident did own | | | | | |
| | | sses. She also indicated | | | | | |
| | | ed and wore upper and | | | | | |
| | | nd she may be wearing | | | | | |
| | | . Room observation at | | | | | |
| | | d the resident had two | | | | | |
| | 1 2 0 | es and a lower denture in | | | | | |
| | | rawer in a blue denture | | | | | |
| | - | the QMA indicated the | | | | | |
| | resident may hav | ve her top dentures in | | | | | |
| | place. Observati | ion of the resident at the | | | | | |
| | time further indi | cated the resident was | | | | | |
| | not wearing her | top dentures. | | | | | |
| | | | | | | | |
| | Interview with C | CNA #2 on 8/20/14 at | | | | | |
| | 9:45 a.m., indica | ted she was regularly | | | | | |
| | scheduled to wor | rk on the 300 hall and | | | | | |
| | she often provide | ed care for Resident #41. | | | | | |
| | She indicated wh | nen she arrived each | | | | | |
| | morning the resi | dent was already out of | | | | | |
| | _ | d seated in the main | | | | | |
| | | e also indicated the | | | | | |
| | _ | requested to wear her | | | | | |
| | glasses nor her d | - | | | | | |
| | _ | ted the night staff had not | | | | | |
| | | ne resident's top dentures | | | | | |
| | were missing. | 10 1001dent o top dentareo | | | | | |
| | or o missing. | | | | | | |
| | In a follow-up in | iterview with CNA #2 on | | | | | |
| | - | p.m., indicated she | | | | | |
| | | lent with feeding and had | | | | | |
| | | resident with her | | | | | |
| | | e in about a month. | | | | | |
| | dentures in place | in avout a month. | | | | | |
| | | | | | | | |

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| | STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530 | | (X2) MULTIPLE CO | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 08/22/2014 |
|--------------------------|--|---|---------------------|--|---------------------------------------|
| NAME OF E | PROVIDER OR SUPPLIER | | B. WING STREET | ADDRESS, CITY, STATE, ZIP CODE | 00,22,20 |
| | | REHABILITATION CENTER | | LER ST IN 46402 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | | LPN #5 on 8/20/14 at atted the resident's top a been located. | | | |
| | 6:00 a.m., indicated or assisted the resisted the resisted in over a week. indicated, when in the mornings | CNA #3 on 8/21/14 at atted she had not observed esident with her dentures. Further interview she dressed the resident she placed her eye lowever, the resident had king them off. | | | |
| | Director on 8/21 indicated the resthat morning and | he Social Service /14 at 10:30 a.m., ident had a dental consult d was measured for a her top denture plate. | | | |
| | 3.1-38(a)(3)(C) 3.1-38)a)(3)(E) | | | | |
| F000323 SS=D | The facility must environment remainst hazards as is possible receives adequate assistance device. Based on observing facility failed to | RVISION/DEVICES ensure that the resident ains as free of accident sible; and each resident | F000323 | Hot water temperatures will be maintained per requirements. Temperatures were adjusted during survey. | 09/21/2014 |

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If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY |
|--|--|---|--------|------------|--|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A RIII | LDING | 00 | COMPLETED |
| | | 155530 | B. WIN | | | 08/22/2014 |
| | | <u> </u> | | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF P | PROVIDER OR SUPPLIEF | ₹ | | 353 TYI | | |
| SOUTH S | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | | DATE |
| | | Fahrenheit on 1 of 4 | | | Temperatures have been monitored throughout the | |
| | | the facility. This had | | | facility to ensure compliance. | |
| | the potential to affect the 21 residents | | | | issues noted. Maintenance | |
| | who resided on I | Unit 3. (Unit 3) | | | Director or designee will take | |
| | who resided on Unit 3. (Unit 3) Findings include: | | | | temperatures at least every shift to ensure continued compliance. Temperature Log will be audit by Maintenance | gs |
| | 1. On 8/19/14 at | t 11:25 a.m., the hot | | | Director to ensure compliance | |
| | water temperatur | re in Room 305 | | | Results of audits will be report | ed |
| | registered 122 de | egrees Fahrenheit. Two | | | the QA team on a monthly bas | |
| | residents resided in this room. | | | | for 6 months or until problem is | |
| | | | | | considered resolved. Problem resolved when there are 3 | 1 IS |
| | 2. On 8/19/14 at 10:17 a.m., the hot water temperature in Room 306 | | | | months of audits with no new issues noted. Monitoring of witemperatures will continue on | |
| | registered 133.5 | degrees Fahrenheit. | | | on-going basis | an |
| | Three residents i | resided in this room. | | | on going basis | |
| | On 8/22/14 at 10:30 a.m., the hot water temperature registered 118 degrees Fahrenheit. | | | | | |
| | 3 On 8/10/1/Los | t 10:23 a.m., the hot | | | | |
| | water temperatu | | | | | |
| | | | | | | |
| | _ | egrees Fahrenheit. Two | | | | |
| | residents resided | I in this room. | | | | |
| | | imperature registered 118 seit on 8/22/14 at 10:33 | | | | |
| | temperature in R | t 9:43 a.m., the hot water Room 309 was 133.5 leit. Two residents | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULT | TPLE CO | NSTRUCTION | (X3) DATE S | |
|--|--|---|------------|------------|--|-----------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 155530 | A. BUILDIN | NG | 00 | COMPL 08/22/ | |
| | | 133330 | B. WING | TD DD D | DDDEGG GWY GWATE WE GODE | 00/22/ | 2014 |
| NAME OF P | PROVIDER OR SUPPLIER | | | | DDRESS, CITY, STATE, ZIP CODE .ER ST | | |
| SOUTHS | SHORE HEALTH & | REHABILITATION CENTER | | | N 46402 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | D | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | · | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | EFIX AG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | COMPLETION DATE |
| TAG | REGULATORT OR | ESC IDENTIF TING INFORMATION) | 17 | AG | | | DATE |
| | | mperature registered 118 eit on 8/22/14 at 10:35 | | | | | |
| | a.m. | | | | | | |
| | temperature in R | t 9:37 a.m., the hot water com 310 was 131.5 eit. Three residents om. | | | | | |
| | The hot water temperature registered 107 degrees Fahrenheit on 8/22/14 at 10:40 a.m. | | | | | | |
| | water temperatur | egrees Fahrenheit. Two | | | | | |
| | | mperature registered 118 eit on 8/22/14 at 10:42 | | | | | |
| | _ | ey process the residents were observed to be alert | | | | | |
| | indicated the hot too high and he water heater dow | 19/14 at 10:51 a.m., water temperatures were would have to turn the | | | | | |
| | 3.1-19(r) | | | | | | |

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| | T OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530 | (X2) MULTIPLE (A. BUILDING B. WING | 00 | (X3) DATE SURVEY COMPLETED 08/22/2014 |
|--------------------------|--|--|-------------------------------------|---|--|
| | ROVIDER OR SUPPLIER SHORE HEALTH & | REHABILITATION CENTER | 353 T | FADDRESS, CITY, STATE, ZIP CODE YLER ST ', IN 46402 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | (X5) COMPLETION DATE |
| F000325 SS=D | UNAVOIDABLE Based on a reside assessment, the faresident - (1) Maintains accer nutritional status, seprotein levels, unle condition demonst possible; and (2) Receives a the a nutritional proble Based on observe interview, the fact acceptable paran maintained relate significant weigh nutritional assess for 3 of 3 resider Nutrition of the ceriteria for Nutri #43, and #79) Findings include 1. The record for reviewed on 8/2 resident's diagnor not limited to, and A Physician's ore | ation, record review and cility failed to ensure neters of nutrition were ed to monitoring a nt loss and ensuring sments were completed ats reviewed for 6 residents who met the tion. (Residents #37, | F000325 | The facility will ensure accept parameters of nutrition and significant weight loss and en nutritional assessments are completed. Residents identificating survey have been assessed by the Dietician. No new issues noted. Other residents have had charts reviewed to ensure that reside have been assessed by Dietician. No new issues noted have been assessed by Dietician. No new issues noted have been assessed by Dietician. No new issues noted have been assessed by Dietician. Staff is been in-serviced on the protofor nutritional assessments. Residents of NAR will be reported to the QA Team for 3 months until problem is considered resolved. Problem will be considered resolved when no new issues are identified for a least 2 months. The facility will be considered resolved. | sure fied o ents ed. sure have col orted or |

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| INAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) TO SUMMARY STATEMENT OF DEFICIENCIES (X6) ID SUMMARY STATEMENT OF DEFICIENCIES (X6) ID SUMMARY STATEMENT OF DEFICIENCIES (X7) IN 46402 Tregular, no concentrated sweet diet. Review of the resident's weekly weight sheet indicated, on 4/2/14 the resident weighed 128 pounds. On 4/9/14, the resident weighed 128 pounds, a loss of ten pounds within a week. The resident's weight loss was greater than 5% within a week, indicating a significant weight loss. On 4/16/14, the resident weighed 125 pounds and on 4/23/14, the resident weighed 126 pounds. Documentation in the Nursing progress notes on 4/8/14 at 8:00 p.m. indicated the resident was encouraged during meal time, appetite poor. On 4/9/14 at 9:30 p.m., the Nursing progress notes indicated the resident at 50% of dinner after set up help and encouragement. On 4/1/1/14 at 9:30 p.m., the Nursing progress notes indicated the resident's appetite was poor, she was fed 25% dinner by writer, required continued encouragement. There was no documentation in the Nursing progress notes indicated the resident's appetite was poor, she was fed 25% dinner by writer, required continued encouragement. There was no documentation in the Nursing progress notes indicated the resident's appetite was poor, she was fed 25% dinner by writer, required continued encouragement. There was no documentation in the Nursing progress notes indicated the resident's appetite was poor, she was fed 25% dinner by writer, required continued encouragement. There was no documentation in the Nursing progress notes indicated the resident's encouragement. There was no documentation in the Nursing progress notes indicated the resident's encouragement. There was no documentation in the Nursing progress notes indicated the resident's encouragement. There was no documentation in the Nursing progress notes indicated the resident's encouragement. There was no documentation in the Nursin | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|--|--|------------------------------|----------------------------|--------|---|------------------|-----------|
| NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION CENTER REFER TAIL READER OF SUPPLIER TAG SIMMARY STATIMENT OF DEFICINCIES REPORT AND YOR IS CONTRIVING HORMATION REGISLATORY OR IS CONTRIVING HORMATION Review of the residents weekly weight sheet indicated, on 4/2/14 the resident weighed 128 pounds, a loss of ten pounds within a week. The resident's weight loss was greater than 5% within a week, indicating a significant weighed 125 pounds and on 4/23/14, the resident weighed 125 pounds and on 4/23/14 the resi | AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DITT | I DINC | 00 | COMPLETI | ED |
| STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 48402 STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 48402 TO GARY, IN 48402 TO GARY, IN 48402 Tregular, no concentrated sweet diet. Review of the resident's weekly weight sheet indicated, on 4/2/14 the resident weighed 128 pounds, a loss of ten pounds within a week, resident weighed 128 pounds, a loss of ten pounds within a week, indicating a significant weight loss was greater than 5% within a week, indicating a significant weight loss was greater than 5% within a week, indicating a significant weight loss was protes in the Nursing progress notes on 4/8/14 at 8:00 p.m. indicated the resident was encouraged during meal time, appetite poor. On 4/9/14 at 9:30 p.m., the Nursing progress notes indicated the resident sprogress notes indicated the resid | | | 155530 | 1 | | | 08/22/20 | 14 |
| SOUTH SHORE HEALTH & REHABILITATION CENTER IN 1910 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) regular, no concentrated sweet diet. Review of the resident's weekly weight sheet indicated, on 4/2/14 the resident weighed 128 pounds, a loss of ten pounds within a week. The resident's weight loss was greater than 5% within a week, indicating a significant weight loss. On 4/16/14, the resident weighed 125 pounds and on 4/23/14, the resident weighed 126 pounds. Documentation in the Nursing progress notes on 4/8/14 at 8:00 p.m. indicated the resident was encouraged during meal time, appetite poor. On 4/9/14 at 9:30 p.m., the Nursing progress notes indicated the resident as escident seed to the OA team at least monthly for three worths or until problem is considered resolved after 2 months of audits will be reported to the OA team at least monthly or three worths or until problem is considered resolved. Problem will be considered resolved ADL care per resident assessment and consent. No new issues noted. The facility will ensure that residents receive ADL per assessment and consent. No new issues noted. Staff will be in-serviced on ADL protocol. Shower sheets have been assessed to ensure care per resident assessment and consent. No new issues noted. Staff will be in-serviced to ADL protocol. Shower sheets have been updated to reflect additional ADL services to be rendered. Results of audits will be reported to OA team at least monthly or until problem is considered resolved after 2. | | | | B. WIIV | | ADDRESS CITY STATE ZID CODE | | |
| CX310 | NAME OF P | PROVIDER OR SUPPLIEF | 8 | | | | | |
| SUMMARY STATEMENT OF DEFICIENCIES TREATMENT CONTINUES BY PRECEDED BY FULL TAG REQUILATION SELS DENTIFYMEN DISPORTATION) TAG REQUILATION SELS DENTIFYMEN DISPORTATION | COLITIL | | DELIABILITATION OFNITED | | | | | |
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| NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES GARY, IN 46402 STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402 STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402 COMPLETION GEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A Physician's order dated 4/23/14, indicated the resident was to receive Boost diabetic control (a nutritional supplement) 8 ounces three times daily with meals. Document refusals in Nurses' notes. Review of the Dietary progress notes indicated an initial nutritional assessment was completed by the RD on 2/28/14. No recommendations were made at this time. The next documented entry by the RD was dated 5/15/14, the resident's significant weight loss was addressed at this time. Review of the plan of care dated 2/25/14 indicated the resident was at risk for alteration in nutritional status related to | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | |
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| NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A Physician's order dated 4/23/14, indicated the resident was to receive Boost diabetic control (a nutritional supplement) 8 ounces three times daily with meals. Document refusals in Nurses' notes. Review of the Dietary progress notes indicated an initial nutritional assessment was completed by the RD on 2/28/14. No recommendations were made at this time. Review of the plan of care dated 2/25/14 indicated the resident was at risk for STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402 (X5) PROVIDER'S RAJOF CORRECTION (X5) CMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S RAJOF CORRECTION (X5) (X5) (X5) (X5) PREFIX TAG PROVIDER'S RAJOF CORRECTION (X5) COMPLETION DATE Susues noted. The facility will ensure that medication classification is documented per drug classification. Resident identified has had MDS updated to reflect proper classification. On new issues noted. Listing of all psychotropics medications have been provided for reference during MDS process Continuing monitoring of classification of drugs will be on-going and any issues noted will be reported to the QA Team. | AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | | |
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| interventions included, but were not | | interventions inc | cluded, but were not | | | | | |
| limited to, monitor and record weight per | | | | | | | | |
| facility policy. Notify the Physician and | | facility policy. N | Notify the Physician and | | | | | |
| RD of significant weight loss and assist | | RD of significan | nt weight loss and assist | | | | | |
| resident during meals when needed. | | | | | | | | |
| | | | | | | | | |
| Interview with the RD on 8/22/14 at | | Interview with the RD on 8/22/14 at | | | | | | |
| 11:35 a.m., indicated that she was not | | 11:35 a.m., indicated that she was not | | | | | | |
| notified of the resident's significant | | | | | | | | |
| weight loss for the week of 4/2-4/9/14. | | weight loss for t | he week of 4/2-4/9/14. | | | | | |
| She also indicated the resident should | | | | | | | | |
| have had a re-weight taken. | | have had a re-we | eight taken. | | | | | |
| 2. On 8/21/14 at 1:30 p.m., Resident #43 | | | _ | | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530 | (X2) MULTIPLE CO | NSTRUCTION 00 | COM | TE SURVEY MPLETED 22/2014 |
|--------------------------|--|--|---------------------|--|-------------------------------|----------------------------|
| | | 100000 | B. WING | | _ | <i></i> |
| | PROVIDER OR SUPPLIER SHORE HEALTH & | REHABILITATION CENTER | 353 TYI | address, city, state, zii LER ST IN 46402 | P CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY) | N SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| | indicated it had l | At that time, she been quite a while since a the Registered Dietitian | | | | |
| | resident was adn 10/6/10. The resincluded but wer obesity, depressing apnea, high bloom | 1/14 at 10:15 a.m. The nitted to the facility on sident's diagnoses te not limited to, morbid on, obstructive sleep d pressure, congestive onic anxiety disorder, | | | | |
| | Set (MDS) Asse indicated the res oriented with a F Mental Status (E resident had no reproblems. The resident of bed off the unit. The extensive assist totally dependent | ssment dated 5/23/24 ident was alert and Brief Interview for BIMS) score of 15. The mood or behavior esident does not transfer, for locomotion on and expression resident needed with dressing, and was to for bed mobility. The mented weight was 360 | | | | |
| | indicated the res altercation in nu resident refused | odated 5/29/14 care plan ident was at risk for tritional status. The to eat most food and she ighed. The Nursing | | | | |

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Event ID:

C5M611

Facility ID: 000369

If continuation sheet

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PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530 | | (X2) MI A. BUII | | NSTRUCTION 00 | (X3) DATE COMPI 08/22 | LETED | |
|--|---|---|--------|---------------------|--|--------|----------------------------|
| | | 155530 | B. WIN | | | | /2014 |
| | PROVIDER OR SUPPLIER | | | 353 TYL | | DE | |
| SOUTHS | SHORE HEALTH & | REHABILITATION CENTER | | GARY, I | IN 46402 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| | ordered, monitor | to provide diet as and record weight, ort labs, double meat at | | | | | |
| | indicated there w | arrent 2014 weight record was no weight available nt refused to be weighed sis. | | | | | |
| | Assessment date completed by the indicated the resinches. Her diag however, the die labs, supplement food preferences ethnic preferences impressions were completed. The were also blank a reverse side of the the resident was Manager on 3/1/ | e all blank and not residents caloric figures and incomplete. The ne Assessment indicated seen by the Dietary Food 13, 9/3/13 and 11/22/13. | | | | | |
| | compliant to diet diets, refuse to b | 3/14 note indicated "Non it, picky, complains of e weighed. Albumin w, high risk. Will refer | | | | | |
| | | ented assessment was not and was by the Dietary | | | | | |

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PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530 | | | LDING | NSTRUCTION 00 | (X3) DATE COMPL 08/22/ | ETED | |
|---|--|--|-------|---------------------|---|------|----------------------------|
| | ROVIDER OR SUPPLIER | REHABILITATION CENTER | • | 353 TYL | DDRESS, CITY, STATE, ZIP CODE LER ST N 46402 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | resident was refu | which indicated the using to be weighed and of the her diet. She was | | | | | |
| | was again by the which was 5/23/resident was more resident's diet, diwere addressed. refused to be we | t documented note by Dietary Food Manager He indicated the rbidly obese. The iagnoses, and appetite The resident still ighed, and had chronic t the food and menu | | | | | |
| | Notes indicated to resident was date indicated her we The resident's prounds, in which The resident was 100% of meals. The RD reviewe current labs. Edadhering to meal ordering from ou Added double means to resident was always. | w of Nutritional Progress the last RD note for the ed 4/25/12. The RD ight was 333 pounds. evious weight was 358 in there was a loss noted. Is morbidly obese and ate Her appetite was good. Id her medications, and ucated resident about Its provided and less itside of the facility. eat for breakfast to sible decrease further | | | | | |
| | indicated an albu | sults dated 11/8/13 umin level was 3.4, a The normal level was | | | | | |

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Event ID:

C5M611 Facility ID: 000369

If continuation sheet

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| | STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530 | | | OONSTRUCTION OO | COMI | E SURVEY PLETED 2/2014 |
|--------------------------|--|---|---------------------|---|----------|------------------------------|
| | PROVIDER OR SUPPLIED | REHABILITATION CENTER | 353 T | CADDRESS, CITY, STATE, ZIP CO YLER ST (, IN 46402 | ODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY) | IOULD BE | (X5) COMPLETION DATE |
| | was 8.1, a low rewas between 8.5 Hemoglobin was The normal level. Review of lab rewaindicated an alborated in alborated in alborated in alborated was 34.4, a low level was between the laborated in alborated in alb | esults dated 5/9/14 umin level of 3.2, a low eium level of 8.1, a low sident's hemoglobin was ing and her Hematocrit er low reading. ab results dated 7/9/14 sident's hemoglobin was | | | | |

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Event ID:

C5M611 Facility ID: 000369

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PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | IDENTIFICATION NUMBER: 155530 | | LDING | 00 | COMPL 08/22/ | ETED |
|-----------|---------------------|--------------------------------|--------|------------------|---|-----------------|------------|
| | | 199990 | B. WIN | | | 00/22/ | 2014 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| SOUTH S | SHORE HEALTH & | REHABILITATION CENTER | | 353 TYI GARY, | IN 46402 | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCY) | | DATE |
| | • | Attending Physician | | | | | |
| | | ional issues for each | | | | | |
| | resident admitted | • | | | | | |
| | | sments will be reviewed | | | | | |
| | quarterly and rev | rised as necessary." | | | | | |
| | | | | | | | |
| | | ne Dietary Food Manager | | | | | |
| | | 5 p.m., indicated staff | | | | | |
| | _ | f go to the resident's | | | | | |
| | room and ask her | what she would like if | | | | | |
| | she does not wan | t the meal or the | | | | | |
| | alternate. He fur | ther indicated his | | | | | |
| | assessment was r | not complete and a RD | | | | | |
| | had not seen the | resident since 4/25/12. | | | | | |
| | | | | | | | |
| | Interview with th | ne RD on 8/22/14 at | | | | | |
| | 10:40 a.m., indic | ated she had attempted | | | | | |
| | to see the residen | nt only one time, and the | | | | | |
| | resident refused l | her visit. She further | | | | | |
| | indicated she had | l been coming to the | | | | | |
| | facility since the | Fall of 2012 and she had | | | | | |
| | not assessed the | resident from a | | | | | |
| | nutritional stand | point. She indicated she | | | | | |
| | | tation of any visits with | | | | | |
| | | er refusal to see her. She | | | | | |
| | indicated she did | not assess the resident | | | | | |
| | back in Septemb | | | | | | |
| | _ | nager had referred the | | | | | |
| | resident to her. | • | | | | | |
| | | r Resident #37 was | | | | | |
| | | 1/14 at 2:46 p.m. The | | | | | |
| | | nitted to the facility on | | | | | |
| | 6/18/14. The res | • | | | | | |
| | | re not limited to, sepsis | | | | | |
| | | | 1 | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MI | JLTIPLE CO | NSTRUCTION | (X3) DATE | |
|--|------------------------|--|---------|---------------|--|-----------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPL | |
| | | 155530 | B. WIN | G | | 08/22/ | 2014 |
| NAME OF PROVIDER OR SUPPLIER | | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| COLITIL | | DELIADII ITATIONI OENITED | | 353 TYL | | | |
| | | REHABILITATION CENTER | | GARY, | IN 46402 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | ` | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | ΓE | COMPLETION DATE |
| TAG | | , | + | IAG | | | DATE |
| | | eumonia. He was feeding tube and urinary | | | | | |
| | catheter. | reeding tube and urmary | | | | | |
| | catheter. | | | | | | |
| | The Admission! | Minimum Data Set | | | | | |
| | | ed 6/25/14 indicated the | | | | | |
| | | endant for transferring | | | | | |
| | _ | 7. The resident was | | | | | |
| | | e hospital on 7/13/14. | | | | | |
| | discharged to the | 2 1105pitai 011 // 15/14. | | | | | |
| | The resident's w | eights were as follows: | | | | | |
| | 6/18/14 207.8 p | • | | | | | |
| | 6/25/14 190.4 p | | | | | | |
| | 7/2/14 178 pour | | | | | | |
| | 7/9/14 174 pour | | | | | | |
| | • | a significant weight loss | | | | | |
| | | or 16.2% of his admission | | | | | |
| | _ | days. There was no | | | | | |
| | _ | of the resident being | | | | | |
| | reweighed. | in the resident semig | | | | | |
| | 3 <u>0</u> -1 4 | | | | | | |
| | On 6/18/14. a die | etary referral was faxed | | | | | |
| | | l Dietician (RD). The | | | | | |
| | _ | he resident weighed | | | | | |
| | | nd received Jevity 1.2 | | | | | |
| | through the feed | | | | | | |
| | | | | | | | |
| | On 6/20/14, the | RD sent the Dietary | | | | | |
| | , | s. The Jevity 1.2 was | | | | | |
| | changed to Nutre | - | | | | | |
| | _ | 00 cubic centimeters (cc) | | | | | |
| | | hift by the way of the | | | | | |
| | 1 | ne Physician accepted the | | | | | |
| | _ | as, and the orders were | | | | | |
| | | • | | | | | |

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Event ID:

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PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530 | | LDING | NSTRUCTION 00 | (X3) DATE COMPI 08/22 | ETED | |
|--|---|---|---------------------|--|----------|----------------------------|
| | PROVIDER OR SUPPLIEF | REHABILITATION CENTER | STREET A | DDRESS, CITY, STATE, ZIP CODE LER ST IN 46402 | <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY) | Ε | (X5) COMPLETION DATE |
| | On the weight rewritten the residdiuretic) 20 mill edema and "coul There were no a recommendation the residents stay additional Physical nutrition. There the Physician has significant weight Interview with the Manager (DM) of the RD indicated notification of the The facility wou her if there were address issues be indicated when so July she had been was not in the facility with the Manager (DM) of the RD indicated when so July she had been was not in the facility would be a solution of the RD indicated when so July she had been was not in the facility with the solution of the RD indicated when so July she had been was not in the facility with the solution of the RD indicated when so July she had been was not in the facility with the solution of the RD indicated when so July she had been notified of loss. Review of the cupolicy titled "Review of the cupolicy titled" "Review of the cupolicy | ne (RD) and the Dietary on 8/22/14 at 10:40 a.m. I she had not received the significant weight loss. It fax a referral form to changes so she could between visits. She with the returned to facility in an notified the resident cility any longer. The House Supervisor on a.m. indicated the e Dietician should have the significant weight arrent 12/06 facility | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | INSTRUCTION | (X3) DATE | | |
|--|-------------------------------|--|------------|-------------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPL | |
| | | 155530 | B. WIN | G | | 08/22/ | 2014 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| SOUTH S | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENCE | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | ded by the House | | | | | |
| | | dentified as current, | | | | | |
| | indicated "if the | monthly weight shows a | | | | | |
| | significant chang | ge (i.e. 5%+/- in 30 days, | | | | | |
| | 7.5% +/- in 90 da | ays or 10% +/- in 180 | | | | | |
| | days) the residen | t will be reweighed. If | | | | | |
| | there is an actual | significant weight | | | | | |
| | change, the resid | ent, family/guardian, | | | | | |
| | physician and die | etitian are notified. The | | | | | |
| | date of notification | on is documented in the | | | | | |
| | Nursing Progress | s notes. When weekly | | | | | |
| | weights are obtain | ned, they must be | | | | | |
| | reviewed weekly | and action must be | | | | | |
| | taken for any sig | nificant change." | | | | | |
| | 3.1-46(a)(1) | | | | | | |
| F000329 | 483.25(I) | | | | | | |
| SS=D | DRUG REGIMEN UNNECESSARY I | | | | | | |
| | | ug regimen must be free | | | | | |
| | | drugs. An unnecessary | | | | | |
| | | hen used in excessive plicate therapy); or for | | | | | |
| | | r; or without adequate | | | | | |
| | - | out adequate indications | | | | | |
| | | e presence of adverse | | | | | |
| | • | ich indicate the dose I or discontinued; or any | | | | | |
| | combinations of th | _ | | | | | |
| | • | ehensive assessment of a | | | | | |
| | | y must ensure that e not used antipsychotic | | | | | |
| | | n these drugs unless | | | | | |
| | antipsychotic drug | therapy is necessary to | | | | | |
| | treat a specific cor | ndition as diagnosed and | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | | |
|--|----------------------|---|---------|---|--|----------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPLE | COMPLETED | |
| | | 155530 | B. WIN | | | 08/22/2 | 2014 | |
| | | | D. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | | |
| NAME OF P | PROVIDER OR SUPPLIER | 8 | | | LER ST | | | |
| SOUTHS | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE. | COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE | |
| | | e clinical record; and | | | | | | |
| | | antipsychotic drugs | | | | | | |
| | _ | ose reductions, and | | | | | | |
| | | ntions, unless clinically n an effort to discontinue | | | | | | |
| | these drugs. | Tan enort to discontinue | | | | | | |
| | _ | review and interview, | F00 | 0329 | The facility will ensure that | | 09/21/2014 | |
| | | d to ensure each resident | | | residents receive necessary | 03/2 | | |
| | | nnecessary medication | | | drugs only. The resident identified during survey has ha | ad | | |
| | related to no ind | ication for the use of an | | | antibiotic discontinued. Other | | | |
| | antibiotic for 1 c | of 5 residents reviewed | | | records have been reviewed t | О | | |
| | for unnecessary | medication of the 5 | | | ensure compliance. No new | | | |
| | residents who m | et the criteria for | | issues noted. Nurses will be in-serviced to ensure that | | | | |
| | unnecessary med | dication. (Resident #87) | | | residents receive necessary | | | |
| | Findings include | | | | drugs only. Director of Nursin designee will audit medication orders at least weekly to ensu | ı ıre | | |
| | 1. The record for | or Resident #87 was | | | continued compliance. Result audits will be reported to the 0 | | | |
| | reviewed on 8/20 | 0/14 at 10:10 a.m. The | | | Team at least monthly for 3 | | | |
| | resident was adn | nitted to the facility on | | | months or until problem is | | | |
| | 3/25/14. The res | sident was sent to the | | | considered resolved. | | | |
| | hospital and adn | nitted on 5/21/14 and | | | | | | |
| | returned to the fa | acility on 6/18/14. The | | | | | | |
| | resident's diagno | oses included, but were | | | | | | |
| | | neumonia, diabetes, and | | | | | | |
| | stroke. | | | | | | | |
| | | | | | | | | |
| | Review of the A | dmission Minimum Data | | | | | | |
| | Set (MDS) Asse | ssment dated 6/24/14 | | | | | | |
| | indicated the res | ident was not alert and | | | | | | |
| | oriented and was | s totally dependent on | | | | | | |
| | staff for all Activ | vities of Daily Living. | | | | | | |
| | | | | | | | | |
| | I = | cian Orders dated | | | | | | |
| | 6/22/14 indicate | d the resident was started | | | | | | |

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE COMPL | | |
|---|----------------------|------------------------------|------------|------------|--|--------|------------|
| ANDILAN | or connection | 155530 | | LDING | 00 | 08/22/ | |
| | | 100000 | B. WIN | | PRESIDENCE CONTROL CON | 00/22/ | 2014 |
| NAME OF F | PROVIDER OR SUPPLIER | | | 353 TYL | DDRESS, CITY, STATE, ZIP CODE | | |
| SOUTH | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · · | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | Augmentin ES 600 | | | | | |
| | | give 5 cubic centimeters | | | | | |
| | | (tsp) bid (twice a day) | | | | | |
| | times 7 days for | a respiratory infection. | | | | | |
| | | nest x-ray results dated | | | | | |
| | | d there were changes | | | | | |
| | noted in the left | lower lobe either due to | | | | | |
| | small amount of | left sided pleural | | | | | |
| | effusion and/or i | nfiltrate. Further review | | | | | |
| | of the chest x-ray | y indicated at the bottom | | | | | |
| | of the page it wa | s noted, "Order for | | | | | |
| | Augmentin 500 | milligrams for 10 days. | | | | | |
| | URI (Upper Res | piratory Infection)." | | | | | |
| | Review of the sa | me chest x-ray results | | | | | |
| | dated 5/18/14 wi | ith a fax date of 6/22/14 | | | | | |
| | indicated at the b | pottom of the page, | | | | | |
| | "Augmentin ES | 600/5 cc 1 tsp-ful bid | | | | | |
| | times 7 days." T | he x-ray results were | | | | | |
| | also initialed by | the Physician. | | | | | |
| | Review of Nursi | ng Progress Notes dated | | | | | |
| | 6/22/14 at 2:00 a | n.m., indicated "Resident | | | | | |
| | resting quietly in | bed. Alert and | | | | | |
| | responsive to ver | rbal and tactile stimuli. | | | | | |
| | Skin warm and o | lry to touch. | | | | | |
| | Respirations unl | abored. Oxygen per | | | | | |
| | nasal cannula at | three liters continuously. | | | | | |
| | | , flushed with 300 cc of | | | | | |
| | • | sing. Tolerating feeding | | | | | |
| | | or vomiting noted. | | | | | |
| | | owel and bladder. Peri | | | | | |
| | care rendered. R | Right arm and hand | | | | | |
| | | - | | | | | |

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Event ID:

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MU | JETIPLE CO | NSTRUCTION | (X3) DATE | | |
|--|----------------------|------------------------------|------------|------------|--|-------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPL | |
| | | 155530 | B. WIN | G | | 08/22 | /2014 |
| NAME OF I | PROVIDER OR SUPPLIEF | | • | STREET A | DDRESS, CITY, STATE, ZIP CODE | • | |
| | | | | 353 TYL | | | |
| SOUTH | SHORE HEALTH & | REHABILITATION CENTER | | GARY, I | N 46402 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | l and repositioned every | | | | | |
| | I | ff. Foley catheter patent | | | | | |
| | | raining clear yellow | | | | | |
| | urine. Oxygen s | aturation 97%. No signs | | | | | |
| | or symptoms of | hypo/hyperglycemia | | | | | |
| | reaction. Head of | of bed elevated, bed in | | | | | |
| | upright position | and call light within | | | | | |
| | reach. In no acu | te distress." | | | | | |
| | | | | | | | |
| | The next docum | ented entry in Nursing | | | | | |
| | Progress Notes v | was on 6/22/14 at 7:30 | | | | | |
| | a.m., which indi- | cated "New order for | | | | | |
| | | 500/5 cc one tsp-ful bid | | | | | |
| | " | e to respiratory infection | | | | | |
| | | the chest x-ray. Left | | | | | |
| | | usion and infiltrate." | | | | | |
| | F | | | | | | |
| | Further review o | of Nursing Progress Notes | | | | | |
| | | ough 6/28/14 indicated | | | | | |
| | | cumentation of any signs | | | | | |
| | | an upper respiratory | | | | | |
| | infection for the | | | | | | |
| | | | | | | | |
| | Review of the M | Iedication Administration | | | | | |
| | | 22/14 indicated the | | | | | |
| | Augmentin was | signed out as given from | | | | | |
| | 6/22-6/28/14. | 2-8 | | | | | |
| | | | | | | | |
| | Interview with the | he Director of Nursing on | | | | | |
| | | o.m., indicated the chest | | | | | |
| | l - | one from May 2014 and | | | | | |
| | | She further indicated the | | | | | |
| | | nitted to the hospital on | | | | | |
| | | ted for pneumonia back | | | | | |
| | 3/22/17 and alca | ica for pricumonia back | | | | | |

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Event ID:

C5M611

Facility ID: 000369

If continuation sheet

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| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY |
|---------------|--|--|--------|---------------|--|-----------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BUI | LDING | 00 | COMPL | ETED |
| | | 155530 | B. WIN | | - | 08/22/ | 2014 |
| NAME OF D | ROVIDER OR SUPPLIER | | _ | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | KOVIDER OK SUPPLIER | | | 353 TYI | LER ST | | |
| | | REHABILITATION CENTER | | | IN 46402 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | ` | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | ΓE | COMPLETION DATE |
| TAG | then. She indica | <u> </u> | + | IAG | | | DATE |
| | | | | | | | |
| | | o support the use of the | | | | | |
| | antibiotic. | | | | | | |
| | 3.1-48(a)(4) | | | | | | |
| | 3.1- 40 (a)(4) | | | | | | |
| | | | | | | | |
| | | | | | | | |
| F000371 | 483.35(i) | | | | | | |
| SS=F | FOOD PROCURE | ξ, | | | | | |
| | STORE/PREPARE | E/SERVE - SANITARY | | | | | |
| | The facility must - | | | | | | |
| | · ' | rom sources approved or | | | | | |
| | local authorities; a | ctory by Federal, State or | | | | | |
| | | , distribute and serve food | | | | | |
| | under sanitary cor | | | | | | |
| | Based on observa | ation, record review and | F00 | 0371 | The dietary department will | | 09/21/2014 |
| | | fility failed to ensure a | | | ensure that all items in the refrigerator or freezer are cover | ered | |
| | • | related to uncovered | | | and dated per protocol. Items | | |
| | | ed food in the walk in | | | identified during survey have | | |
| | - | s had to potential to | | | been discarded. The dietary | _ : | |
| | | 70 residents that received | | | manager has checked all items refrigerator/freezer to ensure | S III | |
| | meals prepared f | from the kitchen. | | | compliance. No new issues | | |
| | | | | | noted. The Dietary Manager h | nas | |
| | Findings include | : | | | in-serviced all staff of proper | | |
| | | | | | storage of food items. The Dietary Manager or designee v | will | |
| | | 05 a.m., the kitchen was | | | audit the refrigerator/freezer at | | |
| | _ | the initial tour with the | | | least daily to ensure continued | | |
| | | (DM). In the walk in | | | compliance. The results of the | | |
| | · · | e was a box dated 7/21/14 | | | audits will be reported to the C Team or at least 3 months or u | | |
| | that contained 2 heads of unwrapped | | | | problem is considered resolve | | |
| | | box of opened raisins | | | Problem will be considered | | |
| | dated 10/21/13, a | | | | resolved when no new issues | | |
| | containers of cre | am cheese dated 7/30/14. | | | identified for at least 2 months | | |
| | | | ı | | | | |

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Event ID:

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530 | | | (X2) MULTIPLE A. BUILDING B. WING | CONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 08/22/2014 |
|--|--|--|-------------------------------------|--|---|
| | ROVIDER OR SUPPLIER | REHABILITATION CENTER | STREE 353 T | T ADDRESS, CITY, STATE, ZIP CODE YLER ST Y, IN 46402 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | (X5) COMPLETION DATE |
| F000412 SS=D | titems should have expired and item to be structured as a structure of the structure of th | GENCY DENTAL S / must provide or obtain source, in accordance this part, routine (to the der the State plan); and services to meet the dent; must, if necessary, in making appointments; or transportation to and office; and must promptly in lost or damaged ist. ation, record review and cility failed to provide | F000412 | The facility will provide dental services for residents as nee Resident identified during su has had her dentures scheduto replaced. Social Director completed an audit to ensure other residents have denture needed. No new issue noted During care plan meetings, | ded. rvey uled has e that s as |

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Event ID:

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|------------------------------|---------|--|---|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | | DDIG | 00 | COMPLI | ETED |
| | | 155530 | A. BUII | | | 08/22/2 | 2014 |
| | | | B. WIN | | DDDEGG CITY CTATE ZID CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| COLITIL | | DELIABILITATION CENTED | | 353 TYI | | | |
| SOUTHS | SHORE HEALTH & | REHABILITATION CENTER | | GARY, | IN 46402 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | ΓE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | (Resident #41) | | | | residents who require dentures | s | |
| | | | | | will be assessed for dentures of | or | |
| | Findings include | • | | | the need for dentures. Audits | | |
| | Tilidings illetude | ·• | | | be conducted at least weekly t | 0 | |
| | 0.04044 | | | | ensure that residents who | | |
| | | :00 p.m., Resident #41 | | | requires have them. Results of audits will be reported to the Q | | |
| | | ated in her wheelchair in | | | team at least monthly for three | | |
| | the main dining | room. She did not | | | months or until problem is | | |
| | appear to have a | ny teeth, and was not | | | considered resolved. Problem | | |
| | wearing dentures | S. | | | will be considered resolved aft | er | |
| | C | | | | 2 months of audits with no new | v | |
| | On 8/20/14 at 8: | 29 a.m., Resident #41 | | | issues noted. | | |
| | | - | | | | | |
| | | ated in her wheelchair in | | | | | |
| | _ | room. She was not | | | | | |
| | wearing dentures | S. | | | | | |
| | | | | | | | |
| | On 8/21/14 at 6: | 10 a.m., Resident #41 | | | | | |
| | was observed pro | opelling herself down the | | | | | |
| | 300 hallway tow | ard the nursing station. | | | | | |
| | She was not wea | _ | | | | | |
| | She was not wea | ang dentares. | | | | | |
| | T1 | cord was reviewed on | | | | | |
| | | | | | | | |
| | | .m. The resident was | | | | | |
| | originally admitt | ted to the facility on | | | | | |
| | 10/18/07 and rea | dmitted on 3/10/14. The | | | | | |
| | resident's diagno | ses included, but were | | | | | |
| | not limited to, in | | | | | | |
| | - | | | | | | |
| | hemorrhage, hypertension, cocaine | | | | | | |
| | abuse, asthma, and convulsions. | | | | | | |
| | | | | | | | |
| | | a Set (MDS) Quarterly | | | | | |
| | | d 6/13/14, indicated | | | | | |
| | under the oral/dental status sections, the | | | | | | |
| | resident had no i | ssues, including being | | | | | |
| | | ng no teeth), or having | | | | | |
| | 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | | 1 | | | | |

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Event ID:

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MU | JLTIPLE CO | NSTRUCTION | (X3) DATE | |
|--|---------------------|------------------------------|---------|------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | DING | 00 | COMPL | |
| | | 155530 | B. WING | G | | 08/22/ | 2014 |
| NAME OF P | ROVIDER OR SUPPLIER | 3 | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 353 TYI | | | |
| SOUTHS | SHORE HEALTH & | REHABILITATION CENTER | | GARY, | IN 46402 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | loosely fitting de | entures. | | | | | |
| | | | | | | | |
| | | re plan related to dental | | | | | |
| | status in the resid | dent's record. | | | | | |
| | | | | | | | |
| | | he resident's family | | | | | |
| | member on 8/19 | /14 at 12:07 p.m., | | | | | |
| | indicated the res | ident was edentulous | | | | | |
| | (having no teeth) |). The resident was to | | | | | |
| | wear dentures, h | owever, when visiting | | | | | |
| | | t in the facility, the | | | | | |
| | | ad her dentures in place. | | | | | |
| | | r at the r | | | | | |
| | Interview with th | he Social Service | | | | | |
| | Director on 8/20 | /14 at 8:29 a.m., | | | | | |
| | | ident was being provided | | | | | |
| | | however, she was unsure | | | | | |
| | if the resident we | | | | | | |
| | | | | | | | |
| | Interview with R | Resident #41 on 8/20/14 | | | | | |
| | | icated she was to wear | | | | | |
| | · · | er, she no longer had | | | | | |
| | dentures. | or, she no longer nad | | | | | |
| | delitares. | | | | | | |
| | Interview with C | MA #1 on 8/20/14 at | | | | | |
| | | ated the resident did own | | | | | |
| | · · | | | | | | |
| | | and lower dentures and | | | | | |
| | - | ring them at this time. | | | | | |
| | | on at the time indicated | | | | | |
| | | a lower denture in the | | | | | |
| | | ver in a blue denture cup. | | | | | |
| | | QMA indicated the | | | | | |
| | _ | ve her top dentures in | | | | | |
| | place. Observati | ion of the resident at the | | | | | |
| | | | | | | | |

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Event ID:

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530 | | | LDING | NSTRUCTION 00 | (X3) DATE COMPL 08/22 | ETED | |
|--|--|--|----------|---------------------|---|------|----------------------------|
| | PROVIDER OR SUPPLIER | REHABILITATION CENTER | <u> </u> | 353 TYL | DDRESS, CITY, STATE, ZIP CODE LER ST N 46402 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | time, further ind not wearing her | icated the resident was top dentures. | | | | | |
| | 9:45 a.m., indicascheduled to worshe often provided She stated when morning the resibed, dressed, and dining room. She resident had not dentures. Further night staff had not resident's top der In a follow-up in 8/20/14 at 12:00 assisted the residentures in placed Interview with L 2:00 p.m., indicated the residentures had not Interview with L 5:55 a.m., indicated the residential missing. Interview with C 6:00 a.m., indicated the residentures with C 6:00 a.m., indicat | dent was already out of diseated in the main e also indicated the requested to wear her er interview indicated the ot reported to her that the ntures were missing. Atterview with CNA #2 on 0 p.m., indicated she lent with feeding and had resident with her e in about a month. APN #5 on 8/20/14 at atted the resident's top | | | | | |

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PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

| Í | | IDENTIFICATION NUMBER: | f ' | | | COMPL | |
|--------------------------|--|--|--------|---------------------|---|--------|----------------------------|
| | | 155530 | B. WIN | | | 08/22/ | 2014 |
| | PROVIDER OR SUPPLIER | REHABILITATION CENTER | | 353 TYL | nddress, city, state, zip code LER ST IN 46402 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| F000431 SS=E | that morning and replacement for I and replacement for I and all controlled drugs periodically reconciliation; and records are in order all controlled drugs periodically reconciliation; and records and biologic must be labeled in accepted profession include the appropriate when application and records are in order all controlled drugs periodically reconciliation; and records are in order all controlled drugs periodically reconciliation; and records are in order all controlled drugs periodically reconciliation; and biologic must be labeled in accepted profession include the appropriate when application and the propriate and the profession includes the appropriate when applications and the propriate and the profession includes the appropriate and the propriate | dent had a dental consult was measured for a her top plate. The top plate dental consult was measured for a her top plate. The top plate dental consult was measured for a her top plate. The top plate dental controlled dental controlled dental controlled dental controlled dental controlled dental controlled determines that dental determines that determines determined and controlled and controlled dental controlled. The top plate determines that determines and that an account of the controlled dental controlled and controlled and controlled and controlled and controlled and controlled and controlled determines that determines th | | | | | |

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Event ID:

C5M611

Facility ID: 000369

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| STATEMEN | IT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE | SURVEY |
|-----------|--|--|--------|------------|--|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BIII | LDING | 00 | COMPL | ETED |
| | | 155530 | B. WIN | | | 08/22/ | 2014 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | C | | 353 TYI | LER ST | | |
| | | REHABILITATION CENTER | | | IN 46402 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCE | | DATE |
| | proper temperatur | ed compartments under re controls, and permit only anel to have access to the | | | | | |
| | permanently affixe storage of controll Schedule II of the Abuse Prevention and other drugs si when the facility u drug distribution s quantity stored is dose can be readi Based on observ facility failed to containers of eye opening for 3 of failed to ensure a multi dose vials secured for 1 of and 500) Findings include 1. On 8/20/14 at multi dose vials unattended on to medication cart of the containers of the containers of the containers of eye opening for 3 of failed to ensure a multi dose vials secured for 1 of and 500) Findings include 1. On 8/20/14 at multi dose vials unattended on to medication cart of the containers of the containers of eye opening for 3 of failed to ensure a multi dose vials unattended on to medication cart of the containers of the containers of eye opening for 3 of failed to ensure a multi dose vials unattended on to medication cart of the containers of the containers of eye opening for 3 of failed to ensure a multi dose vials unattended on to medication cart of the containers of eye opening for 3 of failed to ensure a multi dose vials unattended on to medication cart of the containers of eye opening for 3 of failed to ensure a multi dose vials unattended on the containers of eye opening for 3 of failed to ensure a multi dose vials unattended on the failed to ensure a multi dose vials unattended on the failed to ensure a multi dose vials unattended on the failed to ensure a multi dose vials unattended on the failed to ensure a multi dose vials unattended on the failed to ensure a multi dose vials unattended on the failed to ensure a multi dose vials unattended on the failed to ensure a multi dose vials unattended on the failed to ensure a multi dose vials unattended on the failed to ensure a multi dose vials unattended on the failed to ensure a multi dose vials unattended on the failed to ensure a multi dose vials unattended on the failed to ensure a multi dose vials unattended on the failed to ensure a multi dose vials unattended on the failed to ensure a multi dose vials unattended | Comprehensive Drug and Control Act of 1976 ubject to abuse, except uses single unit package ystems in which the minimal and a missing ily detected. The interview, the ensure multi dose and spray and multi dose and spray and multi dose at drops were dated after the 4 halls. The facility also a medication cart and of insulin were properly the halls. (Halls 200, 300, at 8:10 a.m., a tray of of insulin were observed up of the unlocked | F00 | 00431 | The facility will ensure that mu dose containers are dated and secured per facility protocol. A issues noted during survey we corrected during survey. An a has been conducted by the pharmacy since the survey and no new issues were noted. The staff has been in-serviced on facility protocol relevant to storage and safekeeping of midose containers. DON or designee will conduct audits at least weekly to ensure continu compliance. Results of the aud will be reported to the QA Teafor 3 month or until problem is considered resolved. Problem will be considered resolved where are at least 2 months of audits with no new issues identified. | I All re udit d e ulti t ed dits m | 09/21/2014 |
| | cart unlocked. | ed and the medication | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | NSTRUCTION 00 | (X3) DATE S COMPLE | | |
|--|--|---|------------------|------------------|--|---------|--------------------|
| | | 155530 | A. BUI B. WIN | LDING G | | 08/22/2 | 2014 |
| NAME OF P | PROVIDER OR SUPPLIER | | | STREET A | DDRESS, CITY, STATE, ZIP CODE | | |
| SOUTH S | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | | |
| (X4) ID PREFIX | | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | `` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | DATE |
| | multi dose vials unattended on to on the 500 hall. Interview at that indicated she did | time with LPN #8 not leave any | | | | | |
| | cart. She further stated, "It was only insulin." | | | | | | |
| | 3. On 8/22/14 at 10:30 a.m., there were two multi dose containers of eye drops/ointments observed with no open dates in the medication cart on the 200 hall. | | | | | | |
| | two multi dose c | 10:40 a.m., there were ontainers of nasal sprays open dates in the on the 300 hall. | | | | | |
| | 5. On 8/22/14 at 11:10 p.m., on cart #2 there was an inhaler observed with no resident identifier in the medication cart on the 500 hall. | | | | | | |
| | | PN #2 at that time, aler would be discarded. | | | | | |
| | there was one m | : 11:10 p.m., on cart #1 ulti dose nasal spray ed with no open date, | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530 | | A. BUILDIN | | NSTRUCTION 00 | (X3) DATE : COMPL 08/22/ | ETED | |
|---|--|---|---------------------|---------------|---|------|----------------------------|
| | PROVIDER OR SUPPLIER | | 3 | 53 TYL | DDRESS, CITY, STATE, ZIP CODE LER ST N 46402 | | |
| (X4) ID PREFIX TAG | SUMMARY S (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| | | ose eye drop container to open date in the on the 500 hall. | | | | | |
| | of Injectable Me by the Director of 8/22/14 at 1:37 p opened and the i to use the vial w | arrent Vials and Ampules dications policy provided of Nursing (DoN) on o.m., indicated the date nitials of the first person ere recorded on multi accessory label affixed | | | | | |
| | 9:45 a.m., indicand/or container the open date an | ne DoN on 8/22/14 at ated multi dose vials s should be labeled with d medication carts and uld be properly secured | | | | | |
| | 3.1-25(j) | | | | | | |
| F000441 SS=E | Infection Control F provide a safe, sa environment and t | | | | | | |
| | Control Program เ | establish an Infection | | | | | |

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| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE | | | SURVEY | |
|-----------|---|--------------------------------|--|---------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DI 111 | LDING | 00 | COMPL | ETED |
| | | 155530 | B. WIN | | · · · · · · · · · · · · · · · · · · · | 08/22/ | 2014 |
| | | | B. WIIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIE | R | | 353 TYI | | | |
| SOUTH S | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | | |
| | | | | | 11 10 10 2 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID (F) | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX | * | ICY MUST BE PRECEDED BY FULL | | PREFIX | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCE | | DATE |
| | infections in the fa | procedures, such as | | | | | |
| | | | | | | | |
| | isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | (b) Preventing Spread of Infection | | | | | | |
| | | ction Control Program | | | | | |
| | | resident needs isolation to | | | | | |
| | | d of infection, the facility | | | | | |
| | must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | their food, if direct | t contact will transmit the | | | | | |
| | disease. | | | | | | |
| | | ist require staff to wash | | | | | |
| | | each direct resident contact | | | | | |
| | | ashing is indicated by | | | | | |
| | accepted professi | onal practice. | | | | | |
| | (c) Linens | | | | | | |
| | · · | andle, store, process and | | | | | |
| | | o as to prevent the spread | | | | | |
| | of infection. | · | | | | | |
| | Based on record | review and interview, | F00 | 0441 | The facility will ensure that | | 09/21/2014 |
| | the facility failed | d to ensure all new | | | mantoux 1st and 2nd steps are | | |
| | , | ved either a first and/or a | | | completed prior to hiring. The | | |
| | | erculin mantoux test at | | | employees identified have had 1st and 2nd steps administere | | |
| | * | for 5 of 10 employee files | | | All Negative results. Other file | | |
| | | | | | have been reviewed to ensure | | |
| | | facility also failed to | | | compliance. No new issues | | |
| | | uring a treatment for 2 of | | | noted. The Business Office | | |
| | | served. (CNA #4, CNA | | | Manager or designee will revie | | |
| | #5, RN #1, Dieta | ary Aide #1, and | | | all personnel files prior to hirin | | |
| | Housekeeper #1 |) | | | ensure continued compliance. | | |
| | | | | | Audit sheets for personnel files has been updated to include | 5 | |
| | Findings include | 2. | | | Mantoux Steps. business Offi | ce | |
| | | | | | designee will monitor audit she | | |
| | 1 | | 1 | | 1 | Ų | |

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Event ID:

C5M611

Facility ID: 000369

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SU | | | SURVEY | | |
|--|-------------------------------------|---|--------|---------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DITT | LDDIG | 00 | COMPL | ETED |
| | | 155530 | | LDING | | 08/22/ | /2014 |
| | | | B. WIN | | ADDRESS CITY STATE ZID CODE | | |
| NAME OF F | PROVIDER OR SUPPLIEF | 1 | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| 0011711 | | DELIABILITATION OF VITED | | 353 TYI | | | |
| SOUTHS | SHORE HEALTH & | REHABILITATION CENTER | | GARY, | IN 46402 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | 1. The employe | e files were reviewed on | | | to ensure continued compliand | | |
| | 8/22/14 at 11:30 a.m. The following | | | | Audits will be reported to QA f | or 3 | |
| | employees were | • | | | months or until problem is | | |
| | | | | | considered resolved. Problem | | |
| | | acking of either a first or | | | considered resolved when files for 3 months indicate no new | 8 | |
| | • | rculin mantoux skin test | | | issues. Personnel were | | |
| | and/or a physica | l exam: | | | provided in-service education | on | |
| | | | | | the facility infection control pol | | |
| | A. RN #1 was h | ired on 2/12/14 there | | | and hand washing policy DON | | |
| | was no first or se | econd step tuberculin | | | designed will conduct weekly | | |
| | mantoux skin test completed. | | | | audits of hand washing praction | | |
| | | r | | | throughout the facility and duri | ng | |
| | B. CNA #4 was hired on 8/5/14 there | | | | treatments. Audits will be | | |
| | | | | | conducted at least weekly to ensure compliance. Results of | f | |
| | | econd step tuberculin | | | audits will be reported to QA for | | |
| | | st, or a physical exam | | | months or until problem is | 51 0 | |
| | completed. | | | | considered resolved. Problem | ı is | |
| | | | | | considered resolved when aud | | |
| | C. Dietary Aide | #1 was on 8/1/14 there | | | indicate no new issues for a | | |
| | was no first or so | econd step tuberculin | | | period of 3 months. | | |
| | | st or a physical exam | | | | | |
| | completed. | or or a physical chain | | | | | |
| | completed. | | | | | | |
| | D 0014 115 | 1: 1 7/15/14/1 | | | | | |
| | | hired on 7/15/14 there | | | | | |
| | was no second s | tep tuberculin mantoux | | | | | |
| | skin test comple | ted. | | | | | |
| | | | | | | | |
| | E. Housekeeper | #1 was hired on 6/5/14 | | | | | |
| | _ | ond step tuberculin | | | | | |
| | mantoux skin tes | - | | | | | |
| | manto ax skin to | or completed. | | | | | |
| | Davious of the | arrent 12/06 Tuberculosis | | | | | |
| | | | | | | | |
| | Screening-Admi | | | | | | |
| | • | Tuberculin Skin Tests | | | | | |
| | policy indicated | "All employees shall be | | | | | |
| | screened for tube | erculosis infection and | | | | | |

PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO. | NSTRUCTION | (X3) DATE COMPL | | |
|---|----------------------|------------------------------|-------------|------------|---|--------|------------|
| ANDILAN | or connection | 155530 | | LDING | 00 | 08/22/ | |
| | | 100000 | B. WIN | | PRESIDENCE CANADA CANADA CANADA | 00/22/ | 2014 |
| NAME OF P | PROVIDER OR SUPPLIER | | | 353 TYL | ADDRESS, CITY, STATE, ZIP CODE | | |
| SOUTHS | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · · | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | two-step tuberculin skin | | | | | |
| | | y, prior to beginning | | | | | |
| | employment." | | | | | | |
| | | D : 0.00 | | | | | |
| | | ne Business Office | | | | | |
| | _ | 2/14 at 1:00 p.m., | | | | | |
| | | erculin mantoux skin | | | | | |
| | _ | e physical exams were | | | | | |
| | • | or the above mentioned | | | | | |
| | employees at the | | | | | | |
| | | t 8:37 a.m., LPN #1 was | | | | | |
| | | ng to perform a dressing | | | | | |
| | change. LPN #1 | | | | | | |
| | | and washed her hands | | | | | |
| | with soap and w | | | | | | |
| | | resident's medications | | | | | |
| | | Percutaneous Endoscopic | | | | | |
| | Gastrostomy (PI | · · | | | | | |
| | _ | e medications she | | | | | |
| | _ | ves, washed her hands | | | | | |
| | | ater and donned a clean | | | | | |
| | | She proceeded to remove | | | | | |
| | | dressing from her PEG | | | | | |
| | · · | n cleaned the area with | | | | | |
| | - | tted the area dry and | | | | | |
| | | g gloves she applied | | | | | |
| | | to the site and covered it | | | | | |
| | with a dry gauze | dressing. | | | | | |
| | Review of the cu | arrent Standard | | | | | |
| | | y provided by the | | | | | |
| | | ing (DoN) on 8/21/14 at | | | | | |
| | | eated change gloves | | | | | |
| | | d procedures on the same | | | | | |
| | Soundon tusik und | - procedures on the sume | | | | | |

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Event ID:

C5M611

Facility ID: 000369

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CO | | (X3) DATE SURVEY | |
|--|--|--|---------------|---|---------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED |
| | | 155530 | B. WING | | 08/22/2014 |
| NAME OF P | ROVIDER OR SUPPLIE | R | | ADDRESS, CITY, STATE, ZIP CODE LER ST | |
| SOUTH S | SHORE HEALTH & | REHABILITATION CENTER | | IN 46402 | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX TAG | ` | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE COMPLETION DATE |
| TAG | | ontact with material that | IAG | | DATE |
| | | igh concentration of | | | |
| | microorganisms | _ | | | |
| | microorganisms | • | | | |
| | Interview with t | he Director of Nursing on | | | |
| | 8/21/14 at 9:00 | a.m., indicated the nurse | | | |
| | should have don | nned clean gloves during | | | |
| | the dressing cha | nge. | | | |
| | 2.1.14()(1) | | | | |
| | 3.1-14(t)(1) | | | | |
| | 3.1-18(b)(1) | | | | |
| F000456 SS=F | mechanical, elect equipment in safe Based on observinterview, the far essential kitcher safe operating comilk refrigerator having temperate parameters. This effect 61 of the meals prepared in Findings included On 8/18/14 at 9: | MDITION maintain all essential crical, and patient care e operating condition. vation, record review and acility failed to ensure a equipment was kept in condition related to the r and walk in freezer tures above acceptable is had the potential to 70 residents that received in the kitchen. | F000456 | The facility will ensure that kitchen equipment is kept in so operating condition. This probewas corrected while surveyors were in the building, other refrigerators have been check ensure proper temperature. Note that have been in-serviced on proper temperature protocol. Temperature logs have been updated to include parameters per policy. Dietary Manager/Administrator will be notified if temperatures are no within range for resolution. Results of temperature logs we be reported to the QA Team for | to lo lo lo sff per |

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| | AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | 00 | (X3) DATE COMPL | |
|-----------|---|---|--------|------------------------------------|---|--------------------|------------|
| ANDILAN | or connection | 155530 | 1 | LDING | | 08/22/ | |
| | | .0000 | B. WIN | | ADDRESS CITY OF THE SID CORE | 00,22 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | 353 TYI | ADDRESS, CITY, STATE, ZIP CODE | | |
| SOUTH | SHORE HEALTH & | REHABILITATION CENTER | | 1 | IN 46402 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · · | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | | | DATE |
| | | r (DM). The milk | | | least 3 months or until problem considered resolved. Problem | | |
| | _ | rmometer read 55 | | | will be considered resolved wh | | |
| | | of the August 2014 | | no new issues noted for at least 2 | | st 2 | |
| | - | attached to the side of | | | months. | | |
| | _ | ndicated temperature was | | | | | |
| | _ | norning. The log | | | | | |
| | | op that the refrigerator | | | | | |
| | - | ould be at 41 degrees or | | | | | |
| | | as also a heavy dust | | | | | |
| | | the vent on the front of | | | | | |
| | - | The DM indicated the | | | | | |
| | milk refrigerator | was in need of | | | | | |
| | servicing. | | | | | | |
| | At 0:15 a m tha | walk in freezer inside | | | | | |
| | | | | | | | |
| | | d 20 degrees. The DM not believe that to be the | | | | | |
| | | | | | | | |
| | • | ure, and he placed a | | | | | |
| | | meter in the freezer. A | | | | | |
| | | ogs and chicken were not | | | | | |
| | · · · · · · · · · · · · · · · · · · · | DM indicated those | | | | | |
| | items were put in | | | | | | |
| | | kage of ribs was checked | | | | | |
| | | frozen solid. The freezer | | | | | |
| | | was reviewed, the | | | | | |
| | • | been recorded as 0 | | | | | |
| | | The log indicated at the | | | | | |
| | _ | zer must be kept at 0 or | | | | | |
| | below. | | | | | | |
| | On 8/20/14 at 3: | 15 n m another | | | | | |
| | | made with the DM and | | | | | |
| | | or. The milk refrigerator | | | | | |
| | | · · | | | | | |
| | mermometer rea | d 60 degrees. Review of | | | | | |

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE C | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|---------------|--|-----------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 155530 | A. BUILDING | 00 | 08/22/2014 |
| | | 100000 | B. WING | ADDRESS CITY STATE 710 CORE | 33/22/2017 |
| NAME OF P | PROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP CODE /LER ST | |
| SOUTH | SHORE HEALTH & | REHABILITATION CENTER | | , IN 46402 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) |
| PREFIX TAG | ` | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | COMPLETION DATE |
| 1710 | | log on the outside of the | THE | | DATE |
| | - | cated it was 60 degrees | | | |
| | _ | d 20. A container of | | | |
| | milk was checked and found to be 50 | | | | |
| | | ner of yogurt was found | | | |
| | - | . The DM indicated the | | | |
| | | elow 41 degrees. The | | | |
| | | dicated the food in the | | | |
| | refrigerator woul | ld be thrown away. | | | |
| | - | | | | |
| | At 3:25 p.m. the | walk in freezer | | | |
| | thermometer read 22 degrees. Another | | | | |
| | thermometer in t | the freezer read 20 | | | |
| | degrees. A pack | age of chicken was | | | |
| | found to not be f | rozen solid, and | | | |
| | | ound to be soft. The | | | |
| | Administrator in | dicated the freezer and | | | |
| | _ | not operating properly | | | |
| | and were in need | d of servicing. | | | |
| | 3.1-19(bb) | | | | |
| F000463 | 483.70(f) | | | | |
| SS=D | RESIDENT CALL | SYSTEM - | | | |
| | ROOMS/TOILET/I | | | | |
| | The nurses' station receive resident ca | n must be equipped to | | | |
| | | stem from resident rooms; | | | |
| | and toilet and bath | | | | |
| | | ation and interview, the | F000463 | The call light systems will fund | |
| | · · | ensure a functioning call | | as installed. This problem as resolved while surveyors were | |
| | | ntained on 1 of 4 units | | the facility. All halls have bee | |
| | _ | acility. This had the | | checked to ensure proper | |
| | • | et the 21 residents who | | function of call lights. No new | |
| | resided on Unit 3 | 3. (Unit 3) | | issues noted. In-service will be | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|--|--|------------------------------|------------|-------------|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A RIII | LDING | 00 | COMPLETED |
| | | 155530 | B. WIN | | | 08/22/2014 |
| | | | D. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF P | PROVIDER OR SUPPLIER | | | 353 TYI | | |
| SOUTH S | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | |
| | | | | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | `` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY) | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | • | DATE |
| | | | | | conducted with Maintenance S | |
| | Findings include | : | | | on maintaining proper function of call light system. Maintenar | |
| | | | | | Director or designee will condu | |
| | 1. On 8/19/14 at | t 12:03 p.m., the call | | | audits of system at least week | |
| | | oom of Room 303 was | | | Results of audits will be report | |
| | _ | One resident resided in | | | to the QA Team at least month | |
| | | One resident resided in | | | for 3 months or until problem is | s l |
| | this room. | | | | considered resolved to ensure | |
| | | | | | continued compliance. Proble | m |
| | Interview with th | | | | will be resolved when for 3 | 1 |
| | Supervisor at 12:09 p.m., indicated the system was down for maintenance. | | | | months no new issues are not | ea. |
| | | | | | | |
| | | | | | | |
| | 2 On 8/19/14 at | t 11:25 a.m., the call light | | | | |
| | | of Room 305 was not | | | | |
| | | | | | | |
| | _ | e call light did not light | | | | |
| | * | room nor at the Nurses' | | | | |
| | station. Two res | idents resided in this | | | | |
| | room. | | | | | |
| | | | | | | |
| | 3. On 8/19/14 at | t 10:17 a.m., the call light | | | | |
| | | of Room 306 was not | | | | |
| | | e call light did not light | | | | |
| | _ | | | | | |
| | • | room nor at the Nurses' | | | | |
| | station. Three re | esidents resided in this | | | | |
| | room. | | | | | |
| | | | | | | |
| | 4. On 8/19/14 at | 9:43 a.m., the call light | | | | |
| | in the bathroom | of Room 309 was not | | | | |
| | functioning. The | call light did not light | | | | |
| | _ | room nor at the Nurses' | | | | |
| | - | idents resided in this | | | | |
| | | idents resided in this | | | | |
| | room. | | | | | |
| | | | | | | |
| | 3.1-19(u)(2) | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---|--|--------|---------------|--|-----------------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 155530 | B. WIN | | | 08/22/ | 2014 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| SOUTH | SHORE HEALTH & | REHABILITATION CENTER | | | IN 46402 | | |
| (X4) ID | | FATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY) | ΓE | COMPLETION DATE |
| F000465 SS=E | TABLE ENVIRON The facility must p sanitary, and com- residents, staff and Based on observ facility failed to and sanitary env marred walls, do ceiling tiles, stain dried spillage on poles on 4 of 4 u facility. The fact a sanitary enviror related to an accor refrigerator fans, ceiling vents in 1 throughout the fact potential to affect resided in the fact 5. The Main kitc Findings include 1. During the En 8/22/14 at 10:30 | rovide a safe, functional, fortable environment for d the public. ation and interview, the maintain a functional ironment related to ors, stained floor and med privacy curtains, and walls and tube feeding nits throughout the ility also failed to ensure nment was maintained umulation of dust on sprinkler heads and of 1 kitchens acility. This had the et the 70 residents who cility. (Units 2, 3, 4 and hen) | F00 | 0465 | The facility will maintain a functional and sanitary environment. Issues cited dur the survey have been corrected. All areas were effected and all areas have been corrected. T facility will audit areas cited at least weekly to ensure continu compliance. Staff will be in-serviced on the need to kee equipment clean. An audit too has been established to ensur continued compliance with we audits. Weekly audits will be conducted by Dietary Manage designee and by Maintenance Director or designee to ensure continued compliance. Resul of audits will be reported to the QA team at least monthly. Thi will be an ongoing issue with Caudit reporting. | d. he e p e ekly r or | 09/21/2014 |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|--|---|------------------------------|------------|-------------|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLETED |
| | | 155530 | B. WIN | IG | | 08/22/2014 |
| NAME OF B | PROVIDER OR SUPPLIER | | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF P | KOVIDEK OK SUPPLIER | | | 353 TYL | LER ST | |
| | | REHABILITATION CENTER | | GARY, | IN 46402 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY) | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCE) | DATE |
| | was observed: | | | | | |
| | Unit 2 | | | | | |
| | | | | | | |
| | a. The paint beh | ind the head of the bed | | | | |
| | in Room 205 wa | s chipped. One resident | | | | |
| | resided in this ro | oom. | | | | |
| | h The caulk wa | s peeling away from the | | | | |
| | | | | | | |
| | bathroom sink in Room 206. The sink | | | | | |
| | was also loose. One resident resided in | | | | | |
| | this room. | | | | | |
| | c The paint was | s chipped behind the | | | | |
| | _ | n Room 213. The base | | | | |
| | | ng pole was also dusty | | | | |
| | | esident resided in this | | | | |
| | - | esident resided in this | | | | |
| | room. | | | | | |
| | Unit 3 | | | | | |
| | | | | | | |
| | a. The bathroom | n door in Room 302 was | | | | |
| | chipped and mar | red. The caulking | | | | |
| | around the bathr | oom sink was cracked | | | | |
| | and separated fro | om the wall. The toilet | | | | |
| | was not flushed | and there was a urine | | | | |
| | odor in the room | . Two residents resided | | | | |
| | in this room. | | | | | |
| | | | | | | |
| | b. The walls nex | kt to bed 1 in Room 305 | | | | |
| | were marred. Ty | wo residents resided in | | | | |
| | this room. | | | | | |
| | | | | | | |
| | c. The non-skid | strips next to bed 3 in | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | IULTIPLE CO | NSTRUCTION | (X3) DATE SU | | |
|--|---|------------------------------|-------------|------------------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLE | |
| | | 155530 | B. WIN | | | 08/22/2 | .014 |
| NAME OF F | ROVIDER OR SUPPLIEF | ₹ | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| SOUTH | SHORE HEALTH & | REHABILITATION CENTER | | 353 TYI GARY, | IN 46402 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENC!) | | DATE |
| | | peeling and in disrepair. | | | | | |
| | There was a urine odor in the room and stained floor tile at the foot of the bed. | | | | | | |
| | | | | | | | |
| | Three residents resided in this room. | | | | | | |
| | d Vellow steins | ed floor tile were | | | | | |
| | d. Yellow stained floor tile were observed next to the toilet in the | | | | | | |
| | | om 309. Two residents | | | | | |
| | | | | | | | |
| | resided in this room. | | | | | | |
| | e. The wall below the bathroom sink in | | | | | | |
| | Room 310 was rust stained. The | | | | | | |
| | bathroom door was also marred. Three | | | | | | |
| | residents resided | | | | | | |
| | Tostacints Tostace | in this room. | | | | | |
| | Unit 4 | | | | | | |
| | a. The wood cha | air railing behind the | | | | | |
| | | for bed 1 in Room 401 | | | | | |
| | was cracked. Th | ne base of the of | | | | | |
| | bathroom door v | vas paint chipped and | | | | | |
| | | idents resided in this | | | | | |
| | room. | | | | | | |
| | | | | | | | |
| | b. The bathroon | n door in Room 403 was | | | | | |
| | chipped and mar | rred. Also the edge of the | | | | | |
| | door to the room | n was paint chipped and | | | | | |
| | marred. The ceil | ing tiles located at the | | | | | |
| | foot of bed 2 we | re stained and there was | | | | | |
| | peeling plastic o | n the wheelchair arms for | | | | | |
| | the resident who | resided in bed 2. Two | | | | | |
| | residents resided | l in this room. | | | | | |
| | | | | | | | |
| | c. The brick wa | ll underneath the floor | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY | |
|--|---|------------------------------|------------|------------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A RIII | LDING | 00 | COMPL | ETED |
| | | 155530 | B. WIN | | | 08/22/ | /2014 |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | ₹ | | 353 TYL | LER ST | | |
| | | REHABILITATION CENTER | | | IN 46402 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | `` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | _ | 1 407 was peeling away | | | | | |
| | <u> </u> | wall tile in the bathroom | | | | | |
| | was rusty on the lower end and the door frame was marred. Two residents resided in this room. | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | d. The base of t | he bathroom door in | | | | | |
| | Room 412 was o | chipped and marred. | | | | | |
| | | build up in the tub and on | | | | | |
| | | Γwo residents resided in | | | | | |
| | this room. | | | | | | |
| | uns room. | | | | | | |
| | Unit 5 | | | | | | |
| | | | | | | | |
| | a The side rail | for bed 1 in Room 501 | | | | | |
| | | ed and had dried spillage | | | | | |
| | | | | | | | |
| | l ⁻ | sidents resided in this | | | | | |
| | room. | | | | | | |
| | h The privacy | curtain for bed 1 in Room | | | | | |
| | | | | | | | |
| | | There was also dried urine | | | | | |
| | | t in the bathroom. Two | | | | | |
| | residents resided | I in this room. | | | | | |
| | | a water Carella 101 B | | | | | |
| | 1 1 | curtain for bed 2 in Room | | | | | |
| | | . Three ceiling tiles were | | | | | |
| | | there was dried spillage | | | | | |
| | | nd the head of the bed. | | | | | |
| | Two residents re | esided in this room. | | | | | |
| | 1 79 | and and a state of | | | | | |
| | | ust stains in the bathtub | | | | | |
| | | The bathroom door was | | | | | |
| | | window curtains were | | | | | |
| | loose and missir | ng hooks. Two residents | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | |
|--|---|---|---|----------|---|------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING | | | COMPLETED | |
| 155530 | | B. WIN | G | | 08/22/2014 | |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET A | DDRESS, CITY, STATE, ZIP CODE | |
| NUMBER OF TROVIDER OR SOLITEDER | | | | 353 TYL | | |
| SOUTH SHORE HEALTH & REHABILITATION CENTER | | | | GARY, I | IN 46402 | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | (X5) | |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | | | | TAG | DEFICIENCY) | DATE |
| | resided in this ro | om. | | | | |
| | | | | | | |
| | | ed spillage on the wall | | | | |
| | behind the head | of bed 1 in Room 507. | | | | |
| | The base of the o | over bed table located | | | | |
| | next to bed 1 had | d an accumulation of rust | | | | |
| | at the base. Two | residents resided in this | | | | |
| | room. | | | | | |
| | | | | | | |
| | f. The wall clock | k for bed 2 in Room 508 | | | | |
| | had a section of plastic missing around the edge. The base of the heating/air conditioning unit was paint chipped and | | | | | |
| | | | | | | |
| | | | | | | |
| | rusty. Two residents resided in this | | | | | |
| | - | ients resided in this | | | | |
| | room. | | | | | |
| | g. The door and doorframe for Room | | | | | |
| | _ | | | | | |
| | | and marred. The | | | | |
| | bathroom door was also paint chipped and marred. There was also chipped paint on the air conditioner cover. Two residents resided in this room. h. The bathroom door of Room 512 was chipped and marred. The inside of the | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| tub was dirty and the commode lift seat | | | | | | |
| | | e the tub. Two residents | | | | |
| | resided in this ro | | | | | |
| | | | | | | |
| | Interview with th | ne Maintenance | | | | |
| | Supervisor at the | time, indicated all of | | | | |
| | * | n need of cleaning and/or | | | | |
| | repair. | | | | | |
| | | | | | | |
| 2. On 8/18/14 at 9:05 a.m., the kitchen | | | | | | |

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA (X2) MI | | | | | DATE SURVEY | |
|---|---|--|---|--------|---|--------------------------------|-------------|--|
| AND PLAN OF CORRECTION | | | | DING | 00 | COMPLETED | | |
| 155530 | | | B. WING | · | | 08/22/ | 2014 | |
| NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402 | | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | DO CHENTA N. L. V. OD GODDOWY | | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | F | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DA | | |
| | was observed du the Dietary Mana | ring the initial tour with ager. | | | | | | |
| F000502 SS=D | on the ceiling far the ceiling, the win the dishwashin a heavy accumul refrigerator vent. indicated the abordeaning. 3.1-19(f) 483.75(j)(1) ADMINISTRATION The facility must p services to meet the services to meet the facility failed tests were compliated to the facility failed tests were compliated tests who meet the facility failed tests were compliated tests were compliated. Findings included the record for R reviewed on 8/2 resident was adm 3/10/14. The residented, but we included, but we | rovide or obtain laboratory ne needs of its residents. onsible for the quality and ervices. review and interview, I to ensure laboratory eted as ordered for 1 of 1 ed for death of the 1 t the criteria for death. : esident #39 was I/14 at 9:37 a.m. The nitted to the facility on sident's diagnoses re not limited to, | F000 | 0502 | The facility will ensure laborator tests are completed as ordered Resident identified during survis no longer a resident of the facility. Other charts have beer eviewed to ensure compliance with facility protocol relevant to lab administration. No new issues noted. Nursing staff will be in-serviced on facility protocol for laboratory administration. DON or designee will conduct weekly audits for lab to ensure compliance. Results of labs whereported to QA for at 3 monor until problem is considered resolved. Problem will be considered resolved when no | d. ey n e l col | 09/21/2014 | |
| | dementia and post cerebral vascular | | | | considered resolved when no new issues are identified for at | | | |

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|--|---|-----------------------------------|----------------------------|---------------|---|-----------|--------------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | a. Building 00 | | 00 | COMPLETED | |
| 155530 | | B. WIN | | | 08/22/ | 2014 | |
| | | | D. ((11) | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF PROVIDER OR SUPPLIER | | | | 353 TYI | LER ST | | |
| SOUTH SHORE HEALTH & REHABILITATION CENTER | | | | | IN 46402 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) |
| PREFIX TAG | | | | PREFIX TAG | | | COMPLETION DATE |
| 1710 | accident with lef | | | 1710 | least 2 months. | | DATE |
| | accident with ici | t sided paratysis. | | | | | |
| | There was a Phy | sician order written on | | | | | |
| | There was a Physician order written on 3/15/14 to obtain a urine analysis with | | | | | | |
| | | • | | | | | |
| | culture and sensitivity on 3/17/14. There were no lab results for this test in the | | | | | | |
| | | | | | | | |
| | resident's record. | | | | | | |
| | Intomious with th | o House Cupervisor on | | | | | |
| | Interview with the House Supervisor on 8/21/14 at 12:35 p.m., indicated the urine analysis had not been done as ordered. 3.1-49(a) | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | 3.1 -4 9(a) | | | | | | |
| | | | | | | | |
| | | | | | | | |
| F009999 | | | | | | | |
| | E 1 C 212 1 | 11 | F00 | 0000 | The facility will appure that | | 00/01/0014 |
| | Each facility shall maintain current and accurate personnel records for all | | F00 | 9999 | The facility will ensure that personnel files are complete for | or | 09/21/2014 |
| | | | | | protocol. Employees identified | | |
| | | personnel records for all | | | during the survey have had the | eir | |
| | employees shall include the following: Documentation of orientation to the | | | | files updated with job specific | | |
| | | | | | orientation. Other files have b reviewed to ensure that the fac | | |
| | facility and to the specific job skills. | | | | is compliant. Issues have bee | | |
| | This Chair 1 | | | | corrected as noted. The audit | | |
| | This State rule was not met as evidenced | | | | sheet for new employee files h | as | |
| | by: | | | | been updated to reflect job specific orientation. In-service | ! | |
| | Dogad on magard | raviant and interview | | | has been conducted with the | | |
| | | review and interview, | | | management team and | | |
| | • | failed to provide new | | | designees to educate on the n | | |
| | employees a job specific orientation at | | | | for job specific orientation. Au sheets will be reviewed by the | | |
| | | for 8 of 10 employee files | | | team at least monthly or until | ٠., | |
| | ` | reviewed. (LPN #5, LPN #6, RN #1, | | | problem is considered resolve | d to | |
| | • | , CNA #5, CNA #6, | | | ensure continued compliance. | | |
| | CNA #7, &, CNA | A #8) | | | Problem will be considered | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530 | | | LDING | NSTRUCTION 00 | (X3) DATE COMPL 08/22 / | ETED | | |
|---|---|--|---|--|--|------|----------------------------|--|
| NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | TE | (X5) COMPLETION DATE | |
| | Findings include: | | | | resolved when audits reflect n new issues noted for at least 2 months. | _ | | |
| | 1. The employee files were reviewed on 8/22/14 at 11:30 a.m. The following employee files were lacking documentation of job specific orientation to their jobs: | | | | | | | |
| | A. RN #1 was hired on 2/12/14 B. CNA #5 was hired on 7/15/14. C. CNA #6 was hired on 7/17/14. D. CNA #7 was hired on 6/26/14 E. CNA #8 was hired on 5/1/14 F. LPN #5 was hired on 4/3/14 G. LPN #6 was hired on 6/25/14 H. Activity Aide #1 was hired on 7/25/14 | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | Manager on 8/22 | | | | | | | |

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| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--------------------|------------------------------|----------------------------|----------------|--|------------------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | | | COMPLETED | | | |
| | | 155530 | A. BUILDING B. WING | | | | 08/22/2014 | |
| | | | | | | 33.22.2311 | | |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | | |
| | | | 353 TYLER ST | | | | | |
| SOUTH SHORE HEALTH & REHABILITATION CENTER | | | | GARY, IN 46402 | | | | |
| SOUTH SHOKE HEALTH & KEHABILHAHON SENTEK | | | | O,, | | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID PREFIX | | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | \TE | COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | NIL | DATE | |
| | T | | | | | | Ī | |

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